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"Scire est nescire, nisi id me
Scire alius sciret."

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THE MEDICAL LIFE.

The Presidential Address, delivered on October 8th 1902, at the Opening of the Twenty-ninth Session of the Bristol Medico-Chirurgical Society.

BY

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ALTHOUGH this Society is a clinical and pathological one, I do not wish now to discuss any medical or surgical problem. With your permission I will leave these subjects alone and give you for a few minutes some thoughts of mine on the daily life of medical men, the joys and sorrows of their calling, and the apparent effects of their work upon their character. I shall only deal with a few points which interest me, hoping that they will interest you; and I shall speak from personal experience, believing that in such matters as these it is more valuable than the most carefully collected experience of others.

We often hear ourselves extravagantly praised or derided: in after-dinner speeches, in testimonials and obituary notices our high-mindedness is insisted on in a manner which is more

pleasing than truthful; in fiction, on the other hand, we are generally held up to ridicule in a way we fancy neither pleasing nor truthful. I hope to-night to say what I think, and I wish it to be understood that these few remarks of mine are not intended to serve any special purpose, except to keep you moderately contented for half an hour: nevertheless, it seems to me that it is a good thing sometimes to turn aside from the hurry and impatience of our lives and quietly consider our position; that is what I wish to do to-night.

I suppose the sorrows and joys of the medical life are pretty evenly balanced; it depends here, as always, upon a man's temperament. Black care is sure to sit or walk beside us on many occasions as we go about our daily work; we have vast and awful issues in our hands; and if our conscience is awake, our great responsibilities lie heavily upon our souls, making life a very serious affair indeed. Yet there are many bright gleams constantly illuminating the deeps: the great interest of our work, the fact that we have work set before us that we are bound to do; the confidence placed in us by the greater part of the public; and the humour which abounds everywhere. No one with any sense of the ludicrous can belong to our learned ranks without being sometimes overcome by the absurd things one hears and sees amongst our patients and amongst our colleagues.

And that word "colleague" fitly introduces one of the most noticeable advantages of our profession, namely, our *comradeship*. More than any other set of men, to my thinking, we are ready to help one another, by doing each other's work, by willingly giving advice, by mutual encouragement, and by that strict and wholesome rule of etiquette, or call it rather a moral code, that we shall not slander each other. This last we do not always carry out so strictly as we might; we are only mortal—but we seldom do worse than "damn with faint praise"; and I am sure when patients ask what we think of their pet doctor, we seldom hesitate to say that he is in every way excellent. This is not always truthful, but it is a straining of the truth one can easily forgive. A writer in our enterprising local journal, *The Stethoscope*, expresses himself on this subject as follows:—

"One of the first lessons to be learnt is how to talk to

the public about other professional men. The aspirant for eminence must *never abuse them*. He must either overwhelm them with hyperbolic praise, or change the subject suddenly as if there were something that had better not be said; or what perhaps is best of all, in the full torrent of his laudation, bring in, with due tact, some faint hint that Mr. So-and-So would be even more commendable if he had some little smattering of knowledge of his profession."

We are not, however, given to praise each other on our skill, except in such admirable societies as this, where a man reads notes on three successful cases, and his paper is referred to as interesting and instructive, and he is congratulated (with perhaps mild irony) on the fact that his patients *did* recover. But a little praise is to some men a very great reward, especially to those who are beginning their career, and not only gives pleasure but does a great deal of good. We all have a pretty hard fight and are in need of friendly encouragement. What, for instance, can be a more terrible ordeal for an apprehensive man than to do his first big operation at a hospital, surrounded, perhaps, by critical students and watchful surgeons? When this crisis came for me I was in that state when every sign of praise or blame is caught at with frantic eagerness. I do not know how I got through it; but I remember, and always shall, with a deep sense of thankfulness, that as I went home from the Infirmary, one of my seniors, in the kindness of his heart, gave me some words of praise, probably undeserved, which made the world brighter for many days. The feeling of good fellowship, so important to a gregarious animal like man in his daily battle, is fostered by a society like this. The man who keeps aloof from his fellows, never exchanging ideas with them or discussing pathology and treatment, soon degenerates and becomes incapable of keeping up to date. The great wave of modern knowledge sweeps by him and leaves him on his lonely rock, contented and ignorant. Whereas if he attend these meetings he is bound to see and hear much that is interesting; moreover, by intercourse with his fellows his corners are rounded off, his fads laughed away, and his love for clinical and pathological work deepened. And he gradually

learns too that his best judges are his fellow-workers, not his patients, and that it is to other medical men that he should look for "all help, all sustainment, all reward."

We are always ready, as I have said, to do each other's work; and seeing another man's patients is not always pleasant, especially if one is at all thin-skinned. One occasionally gets rebuffs. The patient asks with a sigh when Mr. So and So is coming home, and looks very depressed when you have to answer, "Not for two weeks." I once was sent for by a lady doctor to give an anæsthetic in a midwifery case. Almost before I entered the room I was received with a loud and jubilant "Thank God, he's come!" which immediately died away into a kind of despairing howl and the—to me—painful explanation that she thought I was a great namesake of mine. Once or twice patients have confided in me the embarrassing news that they are dying to get rid of their own doctor, but don't know how to do it. Probably my patients have frequently said the same of me. This is very trying, but I think the strangest rebuff I ever heard of was given me when I was attending an elderly nervous lady for a Clifton physician. One morning I called and was kept waiting on the door-step whilst someone peeped through the blinds, and a short colloquy was apparently held; the result being that a servant at length opened the door and cheerfully informed me that Miss H. sent her kind regards, but was "too ill to see me this morning!" This is a very pretty instance of unconscious feminine humour. Patients frequently say very amusing things with the most serious intention. They wish to be kind and say "that the medicine does not seem to have hurt them," as if that was something to be very thankful for. During the absence of a well-known Clifton practitioner a patient called on his substitute and explained that she deeply regretted Mr. C.'s absence, as she was so anxious for him to see her husband. "You know," she said, "Mr. C. attended my first husband in his last illness." I may add that Mr. C. has now returned and the lady is, I notice, in deep mourning.

I suppose it was with no idea of deliberate irony that a busy undertaker wrote to one of our past-presidents, asking if he was

offended with him in any way, as he had lately put so little business in his hands. I met this undertaker the other day, and he spoke in high terms of this doctor, so I suppose he has now no complaint against him. It is not only patients and undertakers who say funny things without knowing it. I sent a lady to see a specialist once, and he gave her this advice: "You should take a brisk saline purgative every day before breakfast, and you should spend your mornings on the Downs." And you have probably heard of the eminent man who went from curiosity to a great revival meeting, and sat on a bench in the front of the hall. A Salvation Army officer came round and said: "Oh, are you saved?" to which he answered, rather losing his presence of mind: "Oh, no; I'm a Clifton doctor!" The Salvationist also lost his head, and said: "Oh, I beg your pardon!"

The question of fees is a great worry to some of us. It is a pity we have not a more uniform standard. The public must be very puzzled: but people generally come to the conclusion that if a man charges well, he is a good man; if he charges little, he is worth little. My experience is that patients usually are very good in this respect. Sometimes one comes across stingy and unwilling payers. I once performed tracheotomy on a boy with diphtheria. He was gasping for breath, and cyanosed; but the operation relieved him, and he recovered. Yet when the delighted father paid my bill, he struck out the shillings and paid me in pounds instead of guineas, although he quite realised the value of the operation to his boy. During the "silly season" this year, the *Morning Post*, instead of discussing the sea-serpent, opened a correspondence on the fees of medical men, especially surgeons. Most of the letters were very foolish, but two things struck me. One writer pointed out the great difference between England and Germany in this respect, and said, what no doubt is true, that people go abroad more and more for operations, because they can get the thing done so much more cheaply in Berlin than in London. The other statement I noticed was to the effect that no competent surgeon performed a major operation under 150 guineas; which bears out what I have said as to what the public means by "competency."

Quite recently I had a patient with a tubercular lesion of the wrist. I scraped the part, cleansed it, &c., and gave a bad prognosis. As I understood he was poor, I charged a small fee, and got, not a cheque, but a letter saying that the friends had decided to take him to London. He went, and the wrist was again scraped. The London man charged well, and he had to pay also for a rather expensive nursing-home. I have no particular fault to find with this; but I do object to the next step, which was that the eminent specialist who had operated on him has now, on the return, or rather extension, of the disease, taken him into a hospital as an ordinary patient, and throughout has not communicated with me. We must put down the management of fees as certainly one of the worries of our profession.

The laws of medical etiquette have been for the most part wisely framed, and have, I believe, a good influence on our conduct. But they are often carried out more in the letter than the spirit, and they are a little unjust sometimes to patients. It is made very difficult for them to change their doctor, and some men seem to think they have a prescriptive right to their patients and have taken them on a perpetual lease. I believe great harm is done and much ill-feeling encouraged by these ideas. Let patients go to whom they like: if they leave you, it only shows their bad taste; if they come to you from somebody else, it shows their good taste. In either case, do not trouble!

It is certain that with us the battle is not always to the strong, nor the race to the swift. Success depends on so many things besides knowledge and good intentions. It must be very galling to a well-educated man, whose soul is in his work, to wait year after year for even a small income, whilst men of colossal ignorance are not only making handsome fortunes, but are daily gaining the praise of men. One is almost tempted, when one thinks of this, to agree with the poet:

> "It sounds like voices from the land o spirits
> If anyone obtain that which he merits,
> Or any merit that which he obtains.' [1]

But such a mental attitude is a mistake. In the long run a

[1] Coleridge.

kind of balance is struck, and a man finds his level. And it must be remembered that the public has no means of knowing who are good men and who are frauds except from vague hearsay and the trend of fashion. Some men have a kind of "vogue." Their fame spreads from house to house, and they have their day like all other dogs. How *can* the quack-ridden public tell? They naturally judge by manner, appearance, and by what they call "results." If Miss Jones takes "bile beans for biliousness," and is better in two months, the case is quite plain. "Post hoc ergo propter hoc" is a fallacy that the wisest men fall into. One of the greatest intellects of the eighteenth century was, I suppose, Samuel Johnson, and he pinned his faith to an obscure, unqualified practitioner called Levet, whose fees were "sometimes very small sums, sometimes whatever provisions his patients could afford him." "But," says Boswell, "such was Johnson's predilection for him, and fanciful estimation of his moderate abilities, that I have heard him say he should not be satisfied, though attended by all the College of Physicians, unless he had Mr. Levet with him."

Moreover, many people form their opinions from books they read, and I hope some future president of this Society will deal with that interesting subject, the "doctor in fiction." Thackeray's Dr. Goodenough and Sam Huxter, Allan Woodcourt in *Bleak House*, Dr. Parker Peps and Mr. Pilkins in *Dombey and Son*, George Eliot's Lydgate, Barry's McQueen, to say nothing of Bob Sawyer, Benjamin Allan, and a host of others—what farcical attempts they most of them are! The good ones, as has been pointed out to me, always doing the worst thing for the patient in the kindest possible manner, the rest preternaturally pompous or idiotic; hardly one is at all natural; I do not recognise any of my friends amongst them. Most of the great novelists have very little confidence in us; but one cannot but be struck by the absolute faith that most people place in their doctor. It is one of the blessings, as it is one of the drawbacks, of our profession. If a man goes round with a kind manner and a little address, his patients learn to love him and think him a saint, when in reality he may be utterly unfitted for his work and may be doing great harm.

Faust, you may remember, describes how his father attended people in the pestilence, and was worshipped as a great healer, whereas he killed as many by his treatment as the plague itself did.[1] Some men undoubtedly exercise what may almost be called hypnotism on their patients. I have seen, with astonishment, an operation performed after the mere application of a solution of cocaine to the unbroken skin, absolutely painlessly, "suggestion" apparently causing the anæsthesia, which certainly cocaine, applied in this way, will not do. This confidence must be considered, I think, one of the joys of our profession; it only becomes a sorrow when it is taken from us and given to one of our colleagues.

A great advantage of our calling is its absorbing interest, the interest of intense reality. Disease and Death are the sternest of facts; and in dealing with them we feel we are grappling with forces of Nature, not with theories of laws or morals. In the presence of "the shadow feared by man" everything else is dwarfed into insignificance; and if we look upon our work from a scientific standpoint, there can never be any monotony or ennui. Behind it all, too, is the human element which raises it to a higher level. We are dealing with applied science, but also with the highest product of Nature—the human body.

We are very happily situated in this way, too, that our education and training so well fit us for enjoying other intellectual pleasures; a medical man has excellent facilities for taking up interesting hobbies. To begin with, he has enough general education to appreciate the literature of his own country, and in some cases of other countries. That we have not oftener the taste or inclination to do so is, to my mind, a great pity. We are behind the Church and the Law, I think, in this respect, and thereby lose one of the greatest pleasures of life, and one that is, as I have said, so easily within our reach.

Then, our intercourse with all sorts and conditions of men enables us to see many sides of life, to study character, and therefore should enable us to enjoy one class of literature more. Our smattering of science allows us to understand the scientific

[1] Goethe's *Faust*; First Part.

discoveries and controversies of the day—and these controversies, as we know, are apt to take a wide range into all sorts of social, religious, and educational questions. From our daily work we should learn something of evidence, how to sift the true from the false, and how to gauge character and motives. All this enables us to have mental recreation, and to take a wide and reasonable interest in life.

Again, as we come in contact with all classes in professional and then in friendly intercourse, a medical man is in an excellent position to become a social success, if he has any fancy that way; but from the causes I have mentioned our tastes are too catholic to permit many of us degenerating into mere society men with the narrowed mental horizon which this implies. In hospitality and reasonable social intercourse medicals have many opportunities of indulging, and few men are more acceptable at a dinner-table. Perhaps we do not give up enough of our time to social life: there is so much to read nowadays and so much competition in knowledge, that we cannot "possess our souls" like our forefathers. It is with a feeling of envy and regret that one imagines the literary days when men like Garth and Arbuthnot used to meet Pope at the Kitcat Club. Those times and that type of man have gone never to return; but in a different way the doctor has, from his position, great power in society, a power which should be jealously guarded and restrained. He is consulted about everything, and his opinion looked upon as conclusive. He is the repository very often of terrible secrets: the lurking ghost of insanity, the delinquencies of children, the immorality of parents, the bankrupt condition, fears, despondencies, and family griefs—they are all entrusted to him; and it is to his honour that this trust is seldom violated.

Someone has said that "it would be a very good profession were it not for the patients," and no doubt one is sorely tried by some of the people whom one sees professionally. It is, as a rule, those who have the least the matter with them that test our temper most. They are apt to be exacting, querulous, and unreasonable.

In cases of real illness, however, I, for one, am constantly

struck by the courage and unselfishness of men and women. This is very noticeable amongst those who are wrongly called "the lower orders," and a hospital ward has always seemed to me a place full of high moral lessons.

Our work is, perhaps, almost too absorbing: we cannot escape from it; day and night we are more or less haunted by an undertone of human suffering; and we are often worried by the thought that we may not have done our best. Thackeray, in a passage many of you know, says: "It is the father who is stricken. The terrified wife looks on while the physician feels his patient's wrist, smothering her agonies as the children have been called upon to stay their plays and their talk. Over the patient in the fever, the wife expectant, the children unconscious, the doctor stands as if he were Fate, the dispenser of life and death. He *must* let the patient off this time, the woman prays so for the respite! One can fancy how awful the responsibility must be to a conscientious man; how cruel the feeling that he has given the wrong remedy, or that it might have been possible to do better; how harassing the sympathy with survivors if the case is unfortunate; how immense the delight of victory!" [1]

These are some of the joys and sorrows of our daily life; let us consider very briefly what effect this work has upon our character.

To begin with, there can, I suppose, be no doubt that the aim of our profession, to cure or relieve the sick, is, in itself, a noble one.

When Heracles and Peleus and the sons of the Heroes came back from their different sports on the slopes of Pelion and told Cheiron how they had spent their day, "Asclepias came with downcast eyes and whispered how he had watched the snake cast its old skin and grow young again before his eyes, and how he had gone down into a village in the vale and cured a dying man with a herb which he had seen a sick goat eat. And Cheiron smiled, and said: To each Athenè and Apollo give some gift, and each is worthy in his place; but to this child they have given an honour beyond all honours, to cure while others kill." [2]

[1] Thackeray's *Pendennis*. [2] *The Heroes*, by Charles Kingsley.

However far we have travelled from that beautiful story, nevertheless we may claim this proud honour as our heritage still. But we must discriminate; we must remember that whatever our motives may be, our efforts and results appeal powerfully to our patients, and the full heart finds relief in thanks and praise. But this tribute, however grateful it may be, must not be taken too seriously. We must not think ourselves noble simply because we are told so. As Dr. Johnson says: "The morality of an action depends on the motive from which we act. If I fling half-a-crown at a beggar with intention to break his head, and he picks it up and buys victuals with it, the physical effect is good, but with respect to me the action is very wrong."[1] If I put a dozen different drugs into a patient, thinking that perhaps one of them may, in some occult manner, do him good, and that any way my visits to him will help me to pay my bills and keep my horse, the physical effect may be good, but the motive is not so very exquisite.

We enter our profession partly because we wish to support ourselves. "If our patients live, they pay their fees; if they die, their heirs pay double." As Iago says: "Either way makes my gain." It is right that we should have a wholesome regard for fees, and we are injuring ourselves and even our patients in the long run if we are too lax upon this point. Nevertheless, we must take this into consideration when we discuss the moral standard of our work. Seeing patients is not necessarily heroic.

A man told me that a certain doctor said he frequently saw thirty or forty patients a day. "Think of the good he must do," said my friend; "he deserves a rich reward." I agree with him; I think he deserves "six months' hard." His reward, no doubt, is a large income and a small conscience, the latter decreasing as the former increases. I do not mean to imply that every one who sees patients at this rate and in the same perfunctory manner is deserving of censure—far from it; some of the best and most self-sacrificing men I know do little else than see patients under pressure of time. But think what the effect must be in most cases on a man's character. Tearing round as fast as two horses can carry him, telling one patient

[1] Boswell's *Life of Johnson*.

that he has a "touch of liver," another that he has "congestion of the kidneys," and another "that it might have turned to typhoid if he had not been called in"—never opening a book or examining a specimen—is this man's mind, do you think, expanding under the process, or is he not more likely to become narrowed into a mere half-reflex visiting machine? The visible effect on his appearance and manners is sufficiently grotesque. He becomes stamped with the trade-mark of his avocation; you can tell at once he is medical. He cannot salute you without betraying himself. He says: "How are we this morning?" and you are almost afraid he will thump your chest and ask you to say "ninety-nine" in the public street. No! I cannot think that, so far as seeing patients is concerned, the daily life of such a man does him any good. He may be considered by some a perfect angel; but there is a "soiled glory and a trailing wing," and his aureole has degenerated into a tall hat.

Then, again, must we not admit that if a man has a leaning towards humbug and insincerity, these qualities are fostered and increased by our daily work? The temptation is so great, and there is no one to interfere. This is too wide a subject for me to enter on to-night; but it may be noted that a great deal of so-called "professional humbug" is legitimate, even advisable or necessary. A judge was very severe, I noticed, on a medical man for saying "he gave the medicine as a placebo." Very many of the drugs we give may be classed under this head. I think. I once acted as *locum tenens* to an esteemed friend who held a public appointment and had a sort of dispensary in which he saw his patients. He explained to me that I should find the useful drugs on the left side of the room, the "placebos" on the right. The right side contained several rows of the usual tinctures, infusions, powders, &c., in stoppered bottles, most of which I could not open. But on the left (the useful drugs) side I could find nothing but some rhubarb pills, some more pills labelled "Very strong," a large bottle of iodide of potassium, and in a drawer a very blunt scalpel, some tow, and two dusty splints.

On the other hand if we take the expressed opinions of

medical men at such meetings as these, where we meet in friendly criticism of each other's actions, there are few professions so antagonistic to humbug.

We may call ourselves, I suppose, "men of science." Scientific investigation ought to be one of our chief aims; therefore accuracy of observation should be increased by our work, and this should lead to accuracy of thought. This is a great gain. We get to dislike anything uncertain or obscure; but the scientific spirit is for this very reason not an unmixed blessing. Under the heading of inexact, vague and uncertain are many things which are condemned to our detriment. Many of us practically renounce Art, because in its essence it is often outside the pale of scientific analysis and investigation. "For obscure all great Art is—not with the perplexity of subtle speculation, but with the mystery of vital movement."[1] We find, whether this be the reason or not, a great want of appreciation of artistic productions, whether in painting, poetry, or literature generally, amongst medical men—at least, so it seems to me,—and literature especially is looked upon by many of us as an occasional relaxation rather than as a great force which moulds the character and lives of mankind. This, I believe, is a great mistake, because we must be incomplete without the influences which come from artistic literature, and our style of writing becomes stilted and uninteresting—too much of the catalogue type. "What does it matter," it may be urged, "how you express yourself, so long as you put down your thoughts clearly?" Well, it makes this difference, amongst others, that one style can be read with pleasure, the other can hardly be read at all. We pay very little attention to style, yet we are all, in our reading, more or less influenced by it. One of our past-presidents, Greig Smith, was an artist in almost everything he wrote; and when he gave the address in Surgery at the Association meeting here in 1894, from beginning to end his sentences were examples of how immensely Art adds to the charm of written or spoken words. Yet on looking up the criticisms on this address of his, I have found no definite mention of this carefully sought-for and triumphantly-obtained

[1] *Studies in Literature, 1789—1877*, by Edward Dowden.

result—a result for which he always zealously worked. If this neglect is the result of our training, it must be considered one of its drawbacks.

Some important qualities are fostered by our daily work. We gain, I believe, a reverence for duty. However unpleasant our business, we *have* to do it, and this in time engenders a habit of promptly answering to the stern calls which come to us pretty often "to scorn delights and live laborious days." Courage, presence of mind, readiness, tolerance, and a catholic spirit are fostered by our avocation; so also are self-importance, intellectual conceit, and loss of the faculty of wonder and admiration. We become so accustomed to the greatest marvels of structure and function, that we are apt to become followers of that wretched principle "nil admirari."

Conventional morality, or the reputation of it, we are bound to possess; at all events, those of us in general practice must. With the happy specialist this is not so necessary; indeed, a little wickedness, especially if it be eccentric and amusing, is considered in him a sign of genius, and makes him rather respected as a superior person who need not consider the ordinary humdrum rules of conduct, but is in fact rather above all that.

From of old the medical profession has been the propagator of advanced views, not only in science, but also in social and religious movements. During the stormy period when the principles of evolution were brought so forcibly before the world by Darwin's writings, amidst the howls of execration and denunciation that arose from all quarters, the medical profession recognised the truth of the new doctrines and accepted them. This and many other similar instances prove that there is something in our training which gives a broad mental grasp.

I do not know that we become more charitable or kinder by following the medical profession; it is part of our duty to appear so, and we are judged by appearances. Probably by "assuming a virtue if we have it not," as Hamlet justly says, we gradually become that which we feign, and we therefore gain certain good qualities by the cultivation of their outward signs. As in all other walks of life, the worthiest amongst us

are not usually those whose good deeds are most apparent Some of us know what a severe trial of all the Christian virtues it is to see many out-patients. When I was a student I one day witnessed this incident: An out-patient physician had been doing this work for a long time, and was getting into rather an over-wrought mental condition, when a ragged, miserable-looking woman came in with a sick child, who was emaciated and pale. In answer to the injunction to give the child good food, milk and so forth, the woman said something about not affording it, and went sorrowfully away. The doctor made some excuse about seeing her book, and followed her to the door, where, thinking no doubt no one could see him, he gave her some money. The police would strongly condemn this, and perhaps, logically, one cannot defend such an action; but that woman did not think of logic as she went away, and probably the Recording Angel did not.

I set out with two questions in my mind: Is our profession a happy one to follow? and has its daily work a good or bad effect on our intellects and characters? I am inclined to answer the first of these in the affirmative. Whatever hardships we may undergo, I cannot but think that on the whole the joys preponderate over the sorrows. Some of the most obvious pleasures and pains of our work I have purposely not touched upon. The second question I have dealt with too briefly to arrive at any conclusion worth having, perhaps. Personally, I think that as an intellectual training it is rather over-rated by us. As a moral training, it depends on the kind of work a man does, and this is not always a question of choice. Here, again, I can only express my personal belief, which is that a high-class man is much improved by it, a man with sordid aims is made much worse. It is not a profession fit for everyone, and I think it a great mistake for parents to send boys to medical schools who have no liking for the work and are quite unfitted for it. Some talk as if they had a kind of sacred "call" to follow medicine. I should be inclined to say to some of these as the old Scotch mother did to her son who said he had a "call" to the ministry, "Oh, Johnnie, are ye sure it was na some other noise ye heard?"

One other question suggests itself: Is the medical life likely to lead to reasonable worldly success? We in Clifton and Bristol enjoy the great honour of having more doctors to the number of inhabitants than in any other English town; yet in spite of this there is a low death-rate. It is probable that many of us do not make much, financially, out of it. There are no high positions with handsome salaries as in the Church and the Law. But we must not complain; and, after all, the Englishman's idea, that to make money and hold a high position is heaven, or to be poor and have no social position is hell, may not be quite correct. In that address of Greig Smith's which I have spoken of, he says (and what he writes of the surgeon applies also to the physician): "There is no academy to bestow gold medals on the surgical artist, no crowds to gather round to admire his finished work. In the finest and purest sense the surgeon's art is an art of the home, almost of the fireside, it does not appeal to the populace. The surgeon's highest reward is the moistened eye and the tremulous grip of the hand, which bespeak thankfulness for the bread-winner restored to the home, the mother to the children, the child to the parents. The art of the surgeon has its best reward in blessings, not in fame."

The fame acquired in our profession does not as a rule last very long; here and there some great discovery hands down a man's name to posterity, but for the most part even the leaders of our ranks have a very brief immortality; and the majority of medical men, however heroic their work may be, leave no record behind them, even less than those common soldiers who have given their lives for the empire and lie buried in alien ground, watched over by the Southern stars, for *they*, at least, are remembered in the thankfulness of a great nation. But a little reflection tells us that, however humble a position we may hold, our memory is certain to be kept alive in some grateful hearts, and we may all hope to

> "join the choir invisible
> Of those immortal dead, who live again
> In lives made better by their presence." [1]

[1] George Eliot.

THE RESULTS OF OPERATION IN FIFTY-FOUR CASES OF CANCER OF THE BREAST.

BY

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THE only way to form a true estimate of the value of operation for cancer of the breast is to study the complete records of a large number of consecutive cases. That this may be done, I have prepared a table of my cases, and I am glad to say I have been better able to discover the proportion of recurrences than one might expect, for there is only one case which I have not been able to trace up to the present time or until recurrence was noted.

This series of 54 cases includes all the cases of breast cancer I have operated on, but does not include a few cases I have operated on for sarcoma, or any cases of so-called "duct-cancer," which is a much less malignant type of growth than ordinary breast scirrhus, for I have not operated on any case of the kind. I have had no death from the operation, or for some months after, nor have I had any death in the few cases of operation for sarcoma of the breast. Hence we may assure patients that the risk is very slight, though it is so extensive an operation.

There are 30 cases operated on up to November, 1899, and therefore cases in which the patient might be free from recurrence for three years or longer. Such cases are generally regarded by surgeons as cures. Out of these 30 cases, nine have had no recurrence for three years or longer, *i.e.*, nearly one in every three cases is cured. In two of these nine cases it is eight years since the operation, and in two five years. In all the nine cases the appearance of the growth was typical, and in all but two the opinion as to the nature of the growth formed from its appearance was confirmed either by microscopic section (5 cases) or

the presence of definite growth in the glands (5 cases); only in two cases (19) was the evidence as to the nature of the growth from its naked-eye appearance not corroborated by either microscopic section, or the presence of growth in the glands.

Amongst these 30 cases were several in which the growth was very extensive, and in only three could it be said to be small, *i.e.* the size of a walnut or smaller. Of the 21 cases in which recurrence took place, one had no recurrence for three years, and then had two small recurrences removed, but was free from recurrence when she died suddenly of heart disease five years after operation: another had no sign of recurrence for three years, and then recurrence was discovered and removed this year: she has now another recurrence, but is in good general health. In another case (28) there is now, I think, a small subcutaneous recurrence three years after the operation. As I have not seen her in the last two years, I cannot say how long it has been there; but there is every prospect of its removal, with another long interval of non-recurrence or of actual cure.

Out of the 14 cases operated on between November, 1899, and November, 1901, half are now free from recurrence a year or more after the operation. One case operated on 2 years and 5 months, one 2 years and 3 months, one 1 year and 11 months, one 1 year and 10 months, one 1 year and 8 months, one 1 year and 5 months, and two 1 year ago, are now all free from recurrence. One died from secondary growth two years after operation without local recurrence. These statistics look as if a decidedly larger proportion of cases of cure would eventually be found in this series, for Mr. Watson Cheyne[1] has shown that of 20 cases in which no recurrence had been found at the end of a year, 17 were free from recurrence three years after. Of the cases operated on during the last year, it is too early yet to enquire as to results. Any recurrence I know of I have stated.

I think then we may promise patients not only a remarkable freedom from risk, considering the extent of the operation, but a fair chance of non-recurrence for many years—and if there is no recurrence for many years, probably of non-recurrence altogether. I cannot myself regard cases of non-recurrence for

[1] *Lancet*, 1899, i. 757.

three years as certain cures. I admit that they are quite unlikely to get any recurrence after that time, but we must recognise the fact that now and then they do. I have already referred to two such cases of my own. In one the second operation disclosed more extensive disease buried under the pectorals, just below the inner half of the clavicle, than I expected to find, and possibly when I examined her at the end of the third year after the first operation I may have overlooked this. In the other case there is no doubt small subcutaneous nodules began to recur only after the third year, but they were removed, and the patient lived for two years after the first recurrence and had none at the time of her death. Several other cases of recurrence after three years have been recorded by other surgeons. That cases in which there is no recurrence for three years are very unlikely to get any recurrence later is shown by Mr. Watson Cheyne's[1] 12 cases, in which recurrence had not taken place three years after operation, and three years later nine were still free from recurrence, one had died of a cancerous growth in the intestine (probably primary), one of bronchitis, and one could not be traced.

In only one of my cases in which there has been no recurrence for three years or more was the growth smaller than a hen's egg, but the skin or pectoral muscle was not involved in any, nor were the glands extensively affected. In every case but one an incision was made into the growth before removal to verify the diagnosis, but the knife with which this incision was made was not used again. Unless the growth is large, I have now abandoned this practice for fear of infecting divided lymphatics with cancer cells, and I dissect out the tumour before cutting into it or remove one of the axillary glands for inspection if they are enlarged; but the fact that eight of the cases did so well after this preliminary incision, without previous removal of the growth, shows that it is not such a dangerous practice as some surgeons now maintain.

My records show that very large growths, often involving the muscles and very extensively the glands, are, as might be expected, frequently followed by quick recurrence. One case of

[1] *Loc. cit.*

NO.	NAME AND AGE.	DATE OF OPERATION.	SENT TO ME BY. (Where the patient was not specially sent to me, the name of Hospital in which operation done is given.)	CONDITION OF GROWTH.	RESULT.
				Cases operated on before Nov., 1899.	
1	Mrs. R. 60	April, 1894	General Hospital..	Very large, involving pectoral and skin.	Recurred in six months: position unknown.
2	Mrs A. 53	Aug., 1894	Dr. Burroughs ...	Very large and large mass of glands	Rapid recurrence: position unknown.
3	S. J. 55	Jan., 1894	General Hospital..	Size of orange. Two glands ...	Writes to say now well, eight years after operation. Micro. exam. showed carcinoma.
4	E. F. 46	Jan., 1894	General Hospital..	Size hen's egg. Scirrhus growth in one gland.	Writes to say now well, eight years after operation.
5	M. R. 51	July, 1893	Dr. A. Carr	Moderate size. Scirrhus glands.	No recurrence for three years, then two operations for small nodules under skin. Sudden death from heart disease five years after operation without further recurrence.
6	M. V. 68	Nov., 1894	General Hospital..	Size hen's egg	Recurrent nodules in subcutaneous tissue, not involving pectoral muscle, nine months after operation.
7	E. C. 59	Oct., 1895	Mr. A. W. Peake .	Size hen's egg. Growth in glands. Micro. section showed cancer.	Writes to say now well, seven years after operation.
8	J. M. 36	Jan., 1897	Dr. T. Freeman ...	Two small scirrhus growths ...	Recurrent nodules in seven months in skin, too numerous to remove.
9	E. P. 54	Mar., 1897	General Hospital..	Moderate size and skin involved .	Recurrence seen in fifteen months in supra-clavicular glands and sternum.
10	G. G. 53	April, 1897	General Hospital..	Moderate size	Writes to say now well, five and half years after operation.
11	M. M.	May, 1897	General Hospital..	Extensive growth involving pectoral, and large mass of glands.	Died at home a few months after operation. ? recurrence.
12	E. C. 53	May, 1897	Mr. Churton Pauli	Moderate size, and with skin involved.	Recurrence observed after a year: position unrecorded.
13	S. P. 54	Oct., 1897	Dr. J. Young ...	Size hen's egg. Micro. section showed cancer.	Dr. Young reports now well, five years after operation.
14	Miss S. 30	Oct., 1897	Mr. Windsor Aubrey	Large multiple growths, and extensive gland growth.	Recurrence observed sixteen months later: position unknown.

NO.	NAME AND AGE.	DATE OF OPERATION.	SENT TO ME BY. (Where the patient was not specially sent to me, the name of Hospital in which operation done is given.)	CONDITION OF GROWTH.	RESULT.
15	M. M. 75	Sept., 1897	Dr. L. Lees	Small growth of doubtful nature when removed from breast, but found on section to be cancer.	Still alive. Writes to say she has had recurrence last two years.
16	A. A. 45	Feb., 1898	General Hospital..	Size walnut	Recurrence found one year later in subcutaneous tissue and surface of pectoral muscle, and removed. Then recurred in chest wall, and finally in other breast.
17	Mrs. J. 54	Feb., 1898	Mr. A. W. Peake..	Moderate size. Skin involved and ulcerating.	Small nodule in "chest wall" removed fifteen months after first operation. Died from double pleural effusion two years and three months after operation.
18	S. B. 42	Feb., 1898	General Hospital..	Size orange	Cannot be traced.
19	E. L. 44	Dec., 1898	General Hospital..	Size hen's egg	Writes to say now well, three years and eleven months since operation.
20	Mrs. W.	Jan., 1899	Dr. Ambrose ...	Moderate size	Died from effects of alcohol without recurrence some months after operation.
21	M. C. 56	Jan., 1899	General Hospital..	Size orange and many glands ..	Recurred in six months as nodule in skin.
22	R. E. 52	Jan., 1899	General Hospital..	Moderate size, involving skin, and another small growth in breast.	No recurrence for three years when examined by me; then recurrence found in supra-clavicular glands, and deeply beneath both pectorals just under inner end of clavicle.
23	J. S. 49	April, 1899	Mr. Brew	Size orange and scirrhus glands. Micro. section showed scirrhus.	Mr. Brew reports no recurrence now, three years and six months after operation.
24	H. A. 54	May, 1899	Mr. Brew	Size of orange	Recurred in about six months.
25	E. M. 59	May, 1899	General Hospital.	Very extensive, involving pectoral, skin, and large mass of glands.	Recurred in a few months in skin and supra-clavicular glands
26	Mrs. P. 60	July, 1899	Dr. Belfield	Small growth	Dr. Belfield reports no local recurrence, but died of growths in spine and stomach two years and eleven months after operation.
27	E. S. 43	Aug., 1899	General Hospital..	Size of hen's egg	Rapid recurrence.
28	C. D. 66	Sept., 1899	Mr. F. Peake ...	Moderate size, and skin involved and ulcerating.	Recurrence only just discovered, and of small size, three years and two months after operation.

NO.	NAME AND AGE.	DATE OF OPERATION.	SENT TO ME BY. (Where the patient was not specially sent to me, the name of Hospital in which operation done is given.)	CONDITION OF GROWTH.	RESULT.
29	L. H. 73	June, 1899	Mr. F. Peake ...	Very large growth, with degeneration cyst. Micro. section showed branching columns of epithelial cells.	Examined by me Nov. 5th; no recurrence, three years and three months after operation.
30	Mrs. F. 37	Nov., 1899	Dr. Wilding ...	Small size, and small but scirrhus glands.	Writes to say no recurrence since operation.
				Cases operated on after Nov., 1899.	
31	Mrs. A. 40	Dec., 1899	Mr. Carter	Very large, involving pectoral muscle and supra-clavicular glands.	Rapid recurrence in chest wall.
32	Mrs. Y. 69	April, 1900	Mr. Martin, of Temple Cloud	Growth in each breast. Both breasts removed at interval of five weeks.	Recurred on one side ten months later as nodules in subcutaneous tissue and pectoral muscle, and after their removal as extensive skin growth and died two years after first operation.
33	Mrs. W. 47	July, 1900	Mr. J. Dacre ...	Small growth. Scirrhus growth in glands.	Mr. Dacre reports no local recurrence, but died two years after operation from "growth in lungs."
34	K. L. 40	July, 1900	Children's Hospital	Small	Patient writes to say now free from recurrence, two years and three months after operation.
35	J. H. 64	June, 1900	Women's Ward of Children's Hospital	Small growth	Patient says now free from recurrence, two years and five months after operation.
36	Mrs. A. 48	Sept. 1900	Dr. Belfield ...	Extensive growth, and skin much involved.	Early recurrence. Died two years after operation.
37	C. P. 70	Nov., 1900	General Hospital..	Moderate size	Patient writes to say now quite well, two years since operation.
38	Mrs. T. 58	Dec., 1900	Mr. A. W. Peake..	"Adeno-fibroma" removed by another doctor eighteen months before. Scirrhus nodules near scar and growth in glands.	Patient now writes to say no recurrence.
39	Miss B.	Feb., 1901	Dr. E. Aust Lawrence.	Two small scirrhus nodules in same breast.	Examined by me. No recurrence now, one year and ten months since operation.

NO.	NAME AND AGE.	DATE OF OPERATION.	SENT TO ME BY. (Where the patient was not specially sent to me, the name of Hospital in which operation done is given.)	CONDITION OF GROWTH.	RESULT.
40	Mrs. T.	Mar., 1901	Mr. Martin, ...	Moderate size	Died a year later from "abscess in brain."
41	Mrs V. 37	April, 1901	Dr. Nicholson ...	Small growth. Micro. section showed cancer.	Dr. Nicholson reports no recurrence now, one year and six months after operation.
42	L. W.	July, 1891	General Hospital..	Large growth	Recurrence a few months after operation in subcutaneous tissue and surface of pectorals
43	E. P. 39	Oct., 1891	Mr. A. W. Peake..	Moderate size	Mr. Peake now reports no recurrence.
44	J. C. 56	Feb., 1901	Dr. Belfield ..	Large growth	Recurrence observed a year later attached to pectoral muscle.
45	Mrs. B. 38	Oct., 1901	Mr. Brew ...	Moderate size	Mr. Brew reports no recurrence now, one year after operation.
				Cases operated on within the last	*year.*
46	Mrs. B. 53	Jan., 1902	Mr. A. W. Peake..	Moderate size. Many small cancerous glands removed from above clavicle.	Died from secondary growth in liver, July, 1902, without local recurrence.
47	E. C. 58	Feb., 1892	Dr. Barker ...	Large growths and many glands...	Recurrence two months later.
48	Mrs. P. 60	Feb., 1892	Dr. J. Young ...	Moderate size	Recurred three months later as nodule attached to axillary vein: removed; then recurred in skin at back of axilla and widespread area of skin and supra-clavicular glands. Now small recurrence.
49	H. J. 41	Mar., 1892	General Hospital..	Large growth	
50	M. H. 38	April, 1902	General Hospital..	Large growth, involving muscle. Pectoral removed and also supra-clavicular glands.	
51	H. S. 50	April, 1902	General Hospital..	Moderate size	
52	J. Y. 53	April, 1902	Dr. Hardman, ..	Moderate size	
53	H. S. 46	Aug., 1902	General Hospital.	Moderate size	
54	Mrs. B. 69	Oct., 1902	Mr. L. M. Griffiths	Moderate size. Degeneration cyst.	

NOTE.—I have portions of growth from a large number of these cases still preserved in spirit, but have not yet had time to get sections prepared and examined.

this kind is, however, encouraging; for with a very large growth in which a degeneration cyst had formed, and over which the skin was of a red colour, there is no recurrence at the present time, 3 years and 3 months after the operation. As I have had no death from the operation, even in the most extensive cases, and as occasionally even a very extensive case does very well after operation, we should, I think, operate so that they may have a chance of prolongation of life if they understand that a cure is not probable. I have never refused to operate on account of the size of the growth or the extent of the affection of the axillary glands, and I do not hesitate to excise the axillary vein with the cancerous glands in cases in which it is actually involved in the growth. Very widespread diffusion of nodules in the skin I should regard as a contra-indication, and until the last few years I have so regarded the presence of supra-clavicular glands, but I should now remove them. Fixation to the chest wall would also deter me from operating; not so, however, fixation to the pectoral muscle, as I should in such cases remove the whole of the sternal portion of the muscle. Even with the arm fully raised so as to put the great pectoral muscle thoroughly on the stretch, I have found that in a few cases, though the breast may appear not to be fixed to the great pectoral, yet when the operation is done, it is found to have either invaded the muscle or be firmly adherent to it. I do not now, therefore, ever feel sure before I operate that the pectoral muscle is not involved. Sometimes under the anæsthetic the pectoral can be so stretched that fixation can be discovered when it was not before.

I do not think we can regard a history of the short duration of the growth before operation as of any value for prognosis, for in many cases the patients may have had the growth for a long time before they accidentally noticed it; but the fact that the patient had known of the existence of the growth for some considerable time before its removal, in the cured cases, would be of interest. I find on looking through my records that in two cured cases the growth had been noticed for a year, and in the others for only a few months or even less.

In some of my cases of very extensive growth there has been

shock at the time of the operation, but it has been very exceptional; and in my oldest cases (No. 6 æt. 68, No. 29 æt. 73—a growth very extensive, No. 37 æt. 70, No. 54 æt. 69) it has not been present in any one. Indeed at the age of about 70 several of my patients have gone through this operation as a woman of 40 might be expected to do; and in one case, No. 32, a lady of 69 had both breasts removed with an interval of five weeks, and was none the worse for either operation. Many of these operations take more than two hours, if we include the final preparation of the skin under the anæsthetic (Halsted says his operation takes two to four hours), and yet shock is quite the exception. I would commend this fact to the attention of those who try to rush through an operation, and time it as if it were a record-breaking cycle performance. No one can more strongly object to waste of time in operating than I do, but I as strongly object to that rush and hurry which I do not believe is compatible with the best work. I much more fear loss of blood than I do an extra half-hour or even hour in operating. I know of few more extensive operations than the operation for cancer of the breast ought to be, (Mr. Butlin compares it to amputation through the upper third of the thigh as regards severity), and yet one may often spend two hours over it, and the patient is none the worse. I do not mean that all cases take two hours, but I never trouble if they require more.

I will now describe the method of operating I have employed in these 54 cases. I remove the skin over the breast, and always thoroughly around the tumour itself whether it involves the skin or not. Thus if the tumour is on the sternal side of the breast a very irregular shaped incision may be required. The pectoral fascia is always peeled off with the breast, and if not then completely removed, any portions left are carefully dissected away. I frequently take some surface fibres of the muscle rather than leave any fragments of the fascia. The whole fatty contents of the axilla (containing glands in many cases) are removed. I first define the axillary vein, and then clear out the axilla from above downwards and outwards. No division is made between the breast and the axillary contents, and thus no glands or lymphatics containing cancer cells are cut across.

In nearly all cases I save the long subscapular nerve, but remove the corresponding vessels with the fatty tissue. The fascia and fat between the two pectorals are also removed, and occasionally a nodule of growth is found here. Since 1897 I have made the dissection out of the fatty tissue around the breast more extensively in the midsternal and clavicular directions. There is, of course, nothing original in this operation, but I think it is important to state exactly what I do in considering the results of operation.

I have not adopted Halsted's method of removing the great pectoral muscle unless it is involved in the growth, or the growth is fixed to it; nor his plan of removing the fatty tissue from the posterior triangle in all cases, though I have begun to do so now if I find the highest infra-clavicular glands are infected. I have already stated that I do not regard the presence of such glands, discovered before operating, as a contra-indication to operation, and that I should remove them. Halsted has recorded two cases in which there was no recurrence for three years after their removal at a secondary operation, and therefore I think the outlook in such cases is by no means desperate.

I have carefully looked through my records to ascertain exactly where the recurrences took place, and I find that, unless the nodule in case 48 was a gland, and I do not think it was, there has been no recurrence in the axillary glands, for they have all been removed. In a few cases there has been recurrence in the supra-clavicular glands and once in the sternum. The latter could not be avoided by any method of operating, and should be regarded as a distant metastasis. In the great majority of cases the recurrence has been in the skin, subcutaneous tissue over the great pectoral or in the surface of the muscle itself. When we find recurrent nodules of growth in the subcutaneous tissue involving the surface of the muscle, it is impossible to say in which structure they started. So far then as these observations go, they point to the need of more complete removal of the skin and of either the surface of the muscle, to get rid more thoroughly of the pectoral fascia, or of the sternal portion of the muscle. We must remember when we get recur-

rences in the skin over the area where the breast has been removed, that skin may be axillary skin, or skin over the sternum or elsewhere, dragged into the area from which the breast has been removed at the time of operation, after being extensively separated from the underlying parts. The fact that in several cases the supra-clavicular glands were involved points to the advantage of a systematic removal of glands from above the clavicle at the first operation, as Halsted now does, even though they cannot be felt to be enlarged.

THE INDICATIONS FOR TREATMENT IN NEPHROPTOSIS.

BY

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IN the treatment of movable kidney it is possible that the surgical pendulum has swung too far. Certain it is that operative success has frequently been synonymous with clinical failure, and the patient's symptoms have not been relieved in spite of fixation of the kidney. On the other hand, many cases have been allowed to go on to resulting degenerative changes before operation has been resorted to.

It is clear, therefore, that a more careful discrimination is necessary in the selection of cases for non-operative or operative treatment, and the conclusions upon which this paper is based have been formed after a consideration of the notes of sixty consecutive cases of movable kidney (with symptoms distinctly referable to that condition) which have come under my care.

In recent cases of movable kidney of minor degree, especially when associated with a general emaciation, it is reasonable to suppose that with an increase in the amount of adipose tissue, in which the fatty capsule of the kidney may share, the

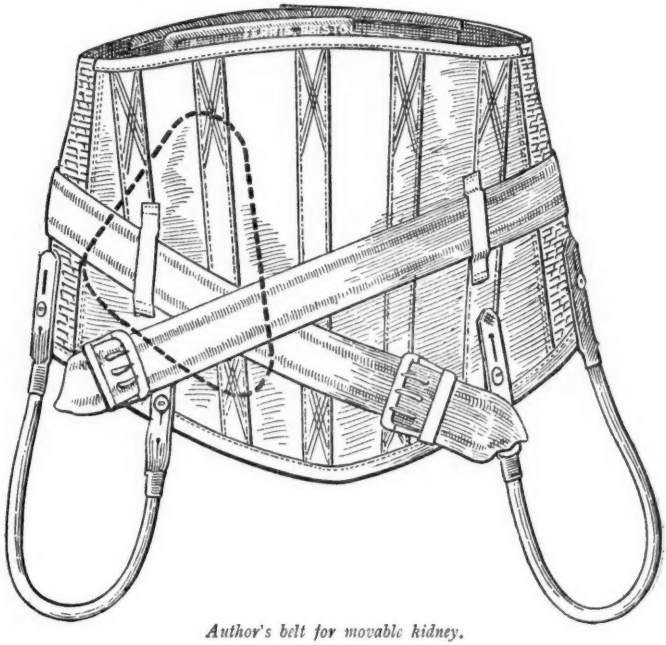
organ may become fixed under suitable conditions of rest in the dorsal position, a liberal diet of fat-forming foods, and massage to prevent wasting of the muscles from disuse. It appears to be true that a movable kidney is spontaneously curable in these circumstances.

Most cases, however, require treatment by abdominal support or by operation.

ABDOMINAL SUPPORT.

Some form of belt is all that is needed in many cases where the displacement does not exceed two or three inches; but where the range of movement is great and associated with "gastric crises" or symptoms of torsion of the renal vessels, abdominal supports often fail to give the necessary relief.

In cases complicated by hydronephrosis—for reasons which will appear later—belts are inadmissible.



Author's belt for movable kidney.

In all cases of movable kidney associated with hysterical and neurasthenic symptoms, or occurring as part of a general splanchnoptosis, belts should certainly be tried, and in many such cases they constitute the only justifiable form of treatment.

In younger women with strong abdominal muscles, belts are far more likely to fail than in older women who have borne many children, and whose abdominal walls are lax.

The beneficial influence of a belt is probably due to its support of the viscera in the lower abdomen, by which the kidney is indirectly prevented from moving from its accustomed site; but I am of opinion that a pad under the belt on the side of the abdomen affected is of accessory service, in spite of all that has been said to the contrary.

The abandonment of the pad by some surgeons, is largely due to the mechanical difficulty of exercising a sufficient direct pressure upon the pad without its becoming irksome to the patient. This difficulty can be overcome by a device which I have used for years with satisfaction, and which consists of a freely-running adjustable band passing obliquely round the outside of the belt guided by loops. This passes round the back, and both ends cross over the position of the junction of the middle and lower thirds of the pad placed under the belt, to be fastened by means of buckles securely fixed—one on either side—to the bottom of the belt. By drawing on the ends of the band when passed through the buckles, a direct pressure upwards and backwards is exerted upon the pad beneath.

Before the belt is applied it is of great importance that the movable kidney should be returned to its normal position.

OPERATION (NEPHROPEXY).

The need for operation is the urgency of the case. When belts fail operative measures are indicated, and it has been already mentioned that a belt is often found to be inefficient in freely mobile kidneys associated with symptoms of gastric crises, or of torsion of the renal vessels. Under such circumstances operation may be undertaken with every hope of a satisfactory result.

The association of hydronephrosis may be regarded as imperatively necessitating surgical interference. Hydronephrosis implies kidney degeneration, and the condition tends to get worse the longer operation is delayed. In one of my cases pyelitis had actually been induced before the patient sought relief.

Such lesions constitute a menace to the life of the patient, and the earlier they are treated the better. Moreover, as is well known, the presence of degenerative changes in the kidneys renders operation more dangerous. In the only two deaths occurring in this series after nephropexy, both cases were associated with hydronephrosis.

Prevention is better than cure, and such considerations as these add greatly to the desirability of operative fixation in all cases of the more severe forms of renal mobility; and the small mortality attending the operation of nephropexy before degenerative changes have ensued, is more than balanced by the positive danger which exists in those cases to which reference has just been made.

In general terms it may be stated that nephropexy is more likely to relive painful symptoms than nervous phenomena, and the indications for operation are certainly weakest in cases of renal mobility associated with neurasthenia or hysterical symptoms, or when forming a part of a general splanchnoptosis.

It is amongst such conditions that most of the cases will be found where operation has failed to relieve the patient of the more distressing symptoms; and in most of them general treatment, combined with the use of a belt, is all that is desirable.

In certain of these cases where the symptoms seem more especially referable to the kidney, it may occasionally be justifiable to resort to nephropexy in the hope of relieving the patients of the chief part of their sufferings; but failures are frequent, and before operation is undertaken the uncertainty of the result should be fully indicated.

It should be borne in mind that a large number of cases of movable kidney are unassociated with any subjective symptoms whatever, and because a movable kidney is found in a case

presenting various hysterical phenomena it by no means follows that the former is the cause of the latter.

So too, when a movable kidney is only part of a general splanchnoptosis, it is not reasonable to suppose that fixation of the kidney will cure the patient of all the symptoms which such a case presents.

It is in cases of movable kidney in association with displacement of other organs that neurasthenia and hysterical symptoms are common, and then there is a double cause of a possible failure of the cure of the symptoms by operative procedure.

In the present series I have had seven cases of movable kidney in which displacements of the uterus also existed—in two of these hysteropexy was performed in addition to nephropexy—and others in association with prolapse of the ovaries or gastroptosis, and I have found treatment by nephropexy on the whole to be unsatisfactory.

Movable kidney should not be overlooked as a possible cause of intractable indigestion and other abdominal troubles, for which no sufficient reason can be given. Operation is necessary in many cases, but those who would avoid disappointment must exercise a wise judgment in the selection of cases for surgical treatment.

OBSERVATIONS ON CASES OF APPENDICITIS.

BY

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THE following observations are based upon a consideration of 28 cases of operation for appendicitis: one half of which were performed for suppurative lesions, and the other half for the removal of the appendix in the interval between attacks. The patients all completely recovered except one who had pneumonia at the time of operation, but for whom it was decided in

consultation that operation afforded the only chance. There were two separate intra-abdominal abscesses in this case, one in the loin and the other in the pelvis, separated by an adherent cæcum, and both were simultaneously drained. I am indebted to his medical attendant for the information that after making hopeful progress for a few days he suddenly developed septic meningitis.

The majority of operations for suppurative appendicitis were performed in private, whereas the majority of those for appendicectomy were performed in hospital practice. The average ages of the patients in the two classes were practically the same, viz., 30 and 31½ respectively; but the extremes differed n the two classes. The youngest patient with suppurative appendicitis was 9, and the oldest two 60 and 68; whereas the youngest for appendicectomy was 15, and the oldest two 48 and 66. In only half the cases of abscess had a previous attack of appendicitis been noted.

We may now consider some of the pathological peculiarities and complications met with.

Appendicectomy for recurrent appendicitis. The conditions which may be found cannot be determined beforehand with any degree of certainty. The appendix may be long or short straight or twisted or kinked; it may be free or buried in a mass of adhesions, or attached to various neighbouring structures; it may be a solid cord or distended by contents. Commonly the lumen is constricted at one part, and beyond this the mucous membrane is swollen and in contact with mucus or a fæcal concretion: on the other hand, the distal extremity may be quite occluded. Hemorrhages into the submucous tissue are frequent features. The position of the appendix varies widely: in one of the series it was to the outer side of the colon, twisted and adherent, close to the liver, the cæcum itself being turned up into the right loin; in another, a small appendix was found buried in firm adhesions in the sac of a femoral hernia. In three cases it was pelvic in position; and in one of these the appendix was long, passed over the iliac vessels, and its outer end was buried in a firm mass of adhesions in the deepest part of the pelvis behind the bladder, whence it could only be

enucleated digitally without inspection. Once the organ was found embedded behind the cæcum; and in the remainder of the cases the appendix projected into the abdomen towards the middle line, either free or adherent to or incorporated with surrounding parts, such as the omentum, anterior parietes, etc. Adhesions were a marked feature in over half the cases; but they do not necessarily remain after previous attacks, for in two cases, with three and two previous attacks respectively, adhesions were absent. The presence of adhesions seems to depend partly on the anatomical position, whether confined or free, and partly on the amount of local peritonitis which accompanied the previous attacks. In half the cases the appendix was either markedly kinked or tortuous, and in one the appendix was so tortuous that when released from its attachments it twirled around as if it were alive. Any marked kink is usually accompanied by a clubbing and fixation of the distal end. In one case the appendix was apparently solid in its distal half, and in another case it was distended into a cyst and was complicated with the presence of a large ovarian cyst. The patients all recovered satisfactorily without any sequelæ, and in no case has the operation been followed by hernia or weakness of the scar.

Suppurative Appendicitis. This condition often gives rise to the greatest anxiety, and to the need of valour on the one hand and of discretion on the other. It is quite impossible to adopt any definite rule or to formulate a fixed creed for surgical action. Each case has to be judged on its merits, and the best guide is the formation of a mental picture of the processes which are taking place in the abdomen. The suppuration may place the patient in the greatest jeopardy within two days of the onset of an attack, or allow the patient to be comparatively comfortable at the end of a week or ten days. Moreover, there is often a delusive subsidence of the symptoms after the first few days which may act as a trap for the unwary: I refer to the fall of temperature, the softening of the pulse, and the diminution of prominence pain and tenderness which accompany the reduction of tension in an abscess when its area is increased. This is also frequently accompanied by the appear-

ance of resonance over an area previously dull, not the normal resonance, but the deceptive resonance of gas formation in the abscess cavity. As a rule, with these deceptive signs there is a quickening of the pulse, but not always so. Nor is the diagnosis of the presence of pus excluded by the patient having a normal temperature. One of the largest localised abscesses I have met with was associated with only occasional pyrexia. Pyrexia is in reality a somewhat accidental phenomenon, depending on an excess of thermogenic organisms over others which have been isolated and found to produce a subnormal temperature.

For these suppurative lesions simple drainage was employed in all, and the amount of pus varied from a drachm or two to half a pint. In no case was it possible with any degree of safety to remove the appendix. In only one case has it caused any subsequent trouble. In one case a slight hernia developed in the scar after an interval of about two years. The abscesses in these cases were intra-peritoneal, and were either single or multilocular. Once the position of the abscess was purely lumbar, once lumbar and retrocæcal, and once it occupied the lumbar and pelvic regions. On two occasions the abscesses occupied the lumbar and umbilical regions; and in one patient, for whom a median incision was requisite, the abscess in the umbilical region communicated by a small opening with another large abscess in the pelvis, which was drained by passing a tube through the first abscess into the second. In three cases the pus was not circumscribed, but was escaping freely into the pelvic peritoneum with well-marked signs of generalising peritonitis. The oldest patient was 68 years of age; and the only fatal case was the one previously referred to, in which pneumonia existed before operation, and death resulted from meningitis.

Perhaps the most interesting case, from the point of view of tenacity of life, was that of a young lady who presented symptoms and signs of general peritonitis, and at the first operation pus was seen escaping from behind the cæcum, and dark serous fluid flowed from the general peritoneal cavity. A few days afterwards a large intra-peritoneal abscess was opened *per rectum* — a route employed for special reasons—

and repeatedly repacked with gauze on subsequent days by the same route. Later on, median cœliotomy was requisite to liberate some stinking serous fluid from amongst the intestines. Then pelvic cellulitis developed, an abscess opened into the bladder causing cystitis, and another abscess pointed by way of the left iliac region and discharged through the median wound. Added to these events, the patient had complete intestinal obstruction, with vomiting and absolute constipation for eight days; and when, with considerable pyrexia, she eventually became pulseless, no hope could be reasonably entertained. Yet with large injections of strychnine she began to revive, and she is now a healthy and vigorous young woman. The patient recovered, it is true, but I hope I shall never meet with the like of this case again.

TUBAL ABORTION.[1]

BY

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DURING the last few years considerable advance has been made in our knowledge of the early changes that take place in a gravid Fallopian tube. We know that when the ovum continues to develop until the tenth or twelfth week, the case usually terminates in rupture of the tube, with its well-known symptoms. But at an earlier period than this, during the first five or six weeks, other changes may take place, involving both the developing ovum and the tube in which it is contained. Of these changes, one of the most important and interesting is that of tubal abortion. We may, I think, define tubal abortion as the expulsion of an impregnated ovum into the peritoneal cavity through the ostium abdominale of an unruptured Fallopian tube. We are rather inclined to imagine that an extrauterine pregnancy usually terminates in rupture of the tube, whereas it is

[1] Paper read at the Meeting of the Bath and Bristol Branch of the British Medical Association, October 29th, 1902.

probable that, compared with "tubal abortion," rupture of the tube is a comparatively rare event. W. J. Taylor says that out of 21 cases of intraperitoneal hæmatocele due to tubal pregnancy, operated upon by himself, and in which he was able to examine the condition of the tube, 14 were due to hemorrhage from an unruptured tube, while only seven were associated with rupture; and Cullingworth's figures are still more striking; he says: "Of 25 cases of pelvic hæmatocele, in which an opportunity occurred of verifying by actual inspection the source of the bleeding, 23 were instances of hemorrhage from the open abdominal ostium of a pregnant Fallopian tube, and only two were due to rupture." During the present year, I have had two of these cases under my care, in one of which I opened the abdomen and removed the unruptured gravid tube. Of course we must not forget the possibility of an intra-pelvic hæmatocele with an unruptured tube being due to a primary ovarium pregnancy, several undoubted cases of which have now been recorded.

In order to understand the pathology of tubal abortion, it will be necessary to describe briefly the changes that take place both in the ovum and in the tube, previous to its occurrence. The changes that take place in the tube:—During the first month or six weeks that portion of the tube in which the ovum is lodged becomes very vascular and turgid, and as the tube expands from the growth of the fœtus and its membranes, the tubal mucous membrane is stretched and its folds effaced. Whether an actual decidual membrane is formed in the tube is from recent investigation rather doubtful. The placental site is represented only by a pseudo-decidual layer, composed of fibrin and connective tissue, so that the surroundings of the ovum are anything but favourable to its continued development. While these changes are taking place in the tube itself, others equally important are occurring at the abdominal ostium, which gradually bring about its occlusion. Careful observation, however, shows that closure of the abdominal ostium is by no means a constant sequel of tubal gestation, and it is in those cases in which the ostium remains patent that tubal abortion is especially liable to occur. The changes that take place in the

developing ovum are of great interest and importance. We know that when the ovum develops in the uterus it is liable to a curious change, whereby it is converted into what is known as a mole. Now precisely the same thing may occur when the ovum develops in the tube; and just as the presence of a mole in the uterine cavity usually excites uterine contraction which end in its expulsion, so the presence of a mole in the outer portion of the tube excites contractions of the tube which result in its expulsion into the peritoneal cavity, and to this event the term tubal abortion is applied. But there is a still further resemblance between uterine and tubal abortion, for in both cases the abortion may be complete or incomplete. If it is complete the hemorrhage usually ceases; if, however, any portion of the ovum is retained, the hemorrhage from the tube persists, just as it would do from the uterus in a case of incomplete uterine abortion.

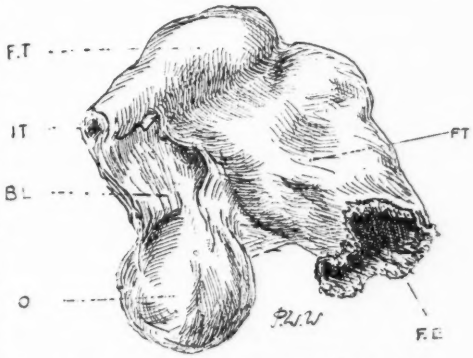
The symptoms of a tubal abortion, although in many cases quite characteristic, are in others very obscure. In a typical case the patient often after a period of sterility goes ten days or a fortnight over her period, when she is suddenly seized with (severe) pain in the lower part of the abdomen, with signs of internal hemorrhage. With or soon after the onset of the pain there is usually a discharge of blood from the uterus, and sometimes a decidual membrane is thrown off. The symptoms, however, are never so severe as in rupture of the tube, and in some cases the patient thinks it is nothing more than a delayed period, or an early miscarriage. The subsequent symptoms depend to a great extent upon whether the "tubal abortion" is of the complete or incomplete variety. If "complete," the hemorrhage from the tube usually ceases, and a small pelvic hæmatocele forms, which is gradually absorbed. If, however, the "abortion" is incomplete, the attacks of abdominal pain recur, the hemorrhage from the tube continues, and if active treatment is not undertaken the patient may bleed to death. On abdominal examination there is often nothing to be made out beyond some tenderness on palpation over the lower part of the abdomen. On vaginal examination, however, the signs are fairly characteristic. Soon after the onset we find a distinct

swelling in Douglas's pouch, behind and to one side of the uterus, the swelling being due to the coagulated blood that has escaped from the open end of the tube and formed a hæmatocele there. We shall also find that as a rule this swelling increases in size with each attack of pain. Time will not allow me to discuss fully the differential diagnosis of tubal abortion, but I should like to draw attention to one condition which is especially liable to be mistaken for it, and that is an ordinary uterine abortion. These are the cases of tubal pregnancy which are sometimes mistaken for an ordinary miscarriage, and we see that the two conditions have many points in common. In both cases the patient has usually missed a period, and is suddenly seized with abdominal pain and uterine hemorrhage. A chief source of error in making a correct diagnosis is that in considering the symptoms, the possibility of an extra-uterine pregnancy is overlooked, and consequently a careful bimanual examination is not made. If this were done the presence of a mass in Douglas's pouch would go far to clear up the doubt. Considerable stress has been laid by some on the importance of examining the uterine discharge for chorionic villi in any doubtful case; of course a positive result would be diagnostic of intrauterine pregnancy, but a negative result would not necessarily mean that the pregnancy was extra-uterine, as the villi are sometimes very difficult to detect, especially in cases where the decidual membrane is disintegrated before it is thrown off. The diagnosis, however, between these two conditions is of the utmost importance as regards treatment, for should we be tempted to explore the uterine cavity in a case of tubal abortion, on the supposition that it was an ordinary miscarriage, the result might be disastrous.

With regard to the treatment of "tubal abortion," there is still some difference of opinion, especially as to when active surgical interference should be undertaken. The difficulty lies in our not being able to tell at once whether it is a case of complete or incomplete tubal abortion. Each case must be carefully studied and kept under constant observation; if the symptoms have never been severe, and tend to progressively improve under appropriate management, an expectant plan of

treatment is indicated; if, on the other hand, the hæmatocele becomes larger and the general condition deteriorates, active treatment is necessary. Operative procedure, which in these cases consists in removal of the affected tube, may be carried out by the abdominal or vaginal route. The former is, I think, preferable, as it allows greater facility for examining the part and dealing with the damaged tube. In conclusion, I give very briefly the notes of a case of tubal abortion, which was under my care this summer, in which I removed the ovary and tube.

Patient, 34 years of age, had had three children; no miscarriages. Youngest child 6½ years of age. Periods since last child have been regular every 28 days. For three weeks previous to her admission into the Hospital, the patient had been suffering from irregular uterine hemorrhage, after having gone eight days over her period. With the hemorrhage she had occasional attacks of abdominal pain; these, however, were not sufficiently severe to compel her to remain in bed. She herself thought she might have had an early miscarriage. The day before her admission into the Hospital (this was three weeks after the first attack of hemorrhage), she was seized with severe abdominal pain, and fainted; she rallied however, and seemed fairly comfortable, but during the night she had another attack, and Dr. Hedley Hill, who had seen her the previous afternoon, was fetched at 2.0 a.m., when he found her quite blanched and almost pulseless. He diagnosed a ruptured tubal pregnancy, and the same day sent her into the Hospital under me. When I saw her in the afternoon she had rallied wonderfully; her pulse was only 85, strong and full. On abdominal examination, there was some fulness and tenderness just above the pubes and Poupart's ligament on right side. On vaginal examination, a mass was felt in Douglas's pouch, pushing the cervix forward close behind the pubes. She complained of no pain, and felt very comfortable. I saw her again in the evening, when her condition was still very good, pulse being only 90. As, however, I thought the swelling in Douglas's pouch had increased, I decided to open the abdomen, when I found the pelvis and lower abdomen filled with blood-clot, the right tube distended to the size of a piece of small intestine, and a large clot



F.T. *Fallopian tube with dilated ostium abdominale* F.E.
B.L. *Broad ligament.*
O. *Ovary.* I.T. *Inner cut end of Fallopian tube.*

protruding from the dilated abdominal ostium. I removed the right tube and ovary, washed out the blood-clot with hot saline fluid, and closed the abdomen without drainage. The patient made a very good recovery. On examining the specimen there is no rupture of the tube to be seen, but its outer portion is much distended, and the ostium abdominale will admit the tip of the little finger. There is a corpus luteum in the ovary. An interesting feature of the case is, that for three weeks the symptoms closely resembled those met with in a case of incomplete uterine abortion, viz., persistent uterine hemorrhage, with occasional attacks of abdominal pain.

VASOMOTOR AND OCULAR PHENOMENA IN RELATION TO RHEUMATOID ARTHRITIS.

BY

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THE vasomotor disturbances that occur in rheumatoid arthritis were ably described by Dr. Kent Spender, to whose facile pen we are indebted for a very vivid and detailed description of the varied phenomena. Anyone who has had the opportunity of coming into contact with a large number of such cases must have been struck by the frequency with which the patients complain of dead-white, or blue fingers. It did not at first strike me that these symptoms of local syncope and asphyxia were identical in nature with those occurring in cases avowedly of the type Raynaud described, but the consideration of a large number convinced me that I could not differentiate them.

Raynaud, and later Galezowski, pointed out that temporary alterations occurred in the circulation of the fundus oculi, and during the past twelve months I examined the fields of vision of over fifty cases of rheumatoid arthritis with coincident symptoms of Raynaud's disease. The fields of vision in all were contracted. They presented the following characteristics: Concentric retraction; the retraction, in some cases amounting almost to extinction, and in others less marked but notable; no marked disparity, as a rule, in degree of affection of either nasal or temporal halves. Homonymous hemianopsia of a fleeting character may be found. Optic atrophy is in some

cases unmistakable, in others the colouration is suggestive of an earlier stage. During a paroxysm of local syncope or asphyxia occurring in the extremities, Mr. Beaumont and myself observed the changes in the retinal circulation described by Raynaud and Galezowski, *i.e.*, definite narrowing of the central artery and its branches; very marked pulsations in the veins, moniliform in character; and I have seen a curious condition in the vitreous, as if one were looking through a gauzy shimmering film.

In order to substantiate the vasomotor nature of these circulatory changes, fields were taken before and after nitrite of amyl. Expansion followed, but in no case did it reach the periphery, hence in each field there were, if one may say so, three circles—the one previous to nitrite of amyl inhalation, the larger one subsequent, finally the normal field; the middle or functional area, transient, due to the unlocking of the vessels by the nitrite; the outermost area, the one of organic change, which has lost its sensitivity to light.

As illustrative of the fact that functional disorders if long continued tend to pass into the region of organic change, the changes above described form a good example.

The subjective visual sensations in these attacks are interesting, and I cannot do better than use the language of one of my patients, a collier, in describing them. "I cannot get a straight glimpse of anything — things glitter, appear double, and jump. I catch sight at one moment and next they are all in a muddle." The phenomena often came on at meal times and occasioned him no little annoyance. "If an attack comes on at my tea, and I look at the teapot or anything, it becomes blurred and stretches out and doubles until it is all teapots, and rubbing my eyes a'int no use."

As further evidence that these attacks end in organic retinal change, may I state that many fields were taken in the interparoxysmal periods and preserved their characteristics when taken some weeks afterwards? As evidence of the continuity of the process with that occurring in the skin, may I cite the fact that they often occur in sequence to a similar attack in the face? And as further proof of their identity, I have known several cases in which an attack in the face, including the external ear,

was followed by giddiness, staggering, reeling—sometimes a fall, also a "roaring noise" with deafness, and occasionally unconsciousness—in brief, a replica of the symptoms common in Menière's disease. Reasoning by analogy with what occurs in the eye, this may throw some light on the origin of the deafness so common in rheumatoid arthritis.

To return to the ocular symptoms. Is not the occurrence of fleeting hemianopsia suggestive of possible extension to the deeper recesses of the brain, *i.e.* the optic tracts?

Burney Yeo, in his work on *Therapeutics*, speaks of the heart as a visceral joint. Is not the term equally applicable to the organ of sight? In a paper shortly to be published I have drawn attention to the frequency with which its movements, like the joints of the limbs, are liable in rheumatoid arthritis to be affected, *i.e.* ataxy, nystagmus, paresis, and even paralysis of its external muscles, not to mention affections of its pupillary movements. In support of my belief that the deeper centres of the brain are subject to the caprices of circulation, may I mention that both Mr. Beaumont and myself have observed the phenomena of "alternating ptosis"? This is (so Aldren Turner says) diagnostic of nuclear affection of cranial nerves. Is it not possible that these transient affections depend upon transient circulatory disturbances affecting the nutrition, and consequently the functioning of the nerve centres? Reasoning by analogy, is it not pertinent that such transient ptoses are common in syphilis, which has such a marked predilection for vascular tissues? Is not the occurrence of episcleritis in rheumatoid arthritis another plea for the justice of the term "visceral joint" as applied to the eye?

In support of my contention that the periarticular swellings of rheumatoid owe their origin to similar vasomotor aberrations, may I adduce the following facts:—(1) A condition of local syncope, &c., in one finger often precedes the formation of spindle swellings in that same digit. I have known the sequence occur in three weeks. (2) The arthrodial swellings and the vasomotor phenomena tend to rise and wane concomitantly. In evidence of the condition being spinal in origin, may I state that—(1) The local asphyxia, when it spreads from the

periphery to the trunk, tends to follow the paths of spinal rather than peripheral nerve distribution. (2) The deep reflexes rise and wane concomitantly with the joint trouble—with this qualification, that the increased myotatic irritability tends to persist between paroxysms of joint trouble—and if we grant allegiance to the toxæmic origin of rheumatoid, we should expect the delicate reflex mechanisms to respond to lighter degress of toxæmia than are adequate to produce the graver phenomena. The constant recurrence of local asphyxia in the limbs leads, as in the retina, to trophic changes; and in this connection I would draw attention to the frequency with which such sequelæ are found on the outer side of the leg from knee to ankle, *i.e.* skin glossy ivory-white, devoid of hairs, diminution of sweat, disturbed sensation. It is remarkable how accurately it plots out the L_5 area of Head, and similar changes may be observed in the upper limb, more commonly over the dorsum of hand and forearm.

The fact that scleroderma occurs in association with rheumatoid arthritis and Raynaud's disease is also suggestive.

The muscular changes in rheumatoid arthritis are also interesting. The similarity of the cramps and spasms of early rheumatoid to those occurring in tetany is notable some time ago, and in this connection may I adduce a striking symptom, *i.e.* the presence of Chvostek's symptom in rheumatoid? I have elicited it in the case of the facial, ulnar, median nerves, &c.

Another similarity is found in the fact that transient obscurations of vision occur in tetany, and also periarticular swellings. I would advert also to the evanescent swelling of muscles that occur, and coincide with exacerbation in neighbouring joints. The bicipital muscles show this well in affections of the elbow. The later atrophy is not, I think, that of disuse. It may be quite marked when there is no fixation; furthermore, spinally related muscles, though remote, also suffer coincidently.

The fact that rheumatoid and Graves's disease occur frequently in one and the same patient is, I think, very interesting, because of the marked vascular characteristics of the latter. I have often thought that here might be found a means of reconciling the conflicting statements with regard to the

quickened pulse-rate in rheumatoid. In an attempt to prove that these diseases possibly in addition to clinical similitude have a common bond of causality as regards their origin, I would enlist any etiological factors common to them. Dilatation of stomach and gastric ulcer are known antecedents of tetany. Bouchard states the former is common in rheumatoid. I have seen several cases supervene on peptic ulcer. Tetany occurs after infectious diseases. Rheumatoid is very common after influenza "sore throats," and a few give a history of pneumonia. Tetany is commonly associated with lactation and pregnancy; and the same may be said of rheumatoid, in that it often comes on after confinements. I have known it come on during pregnancy. I have before stated that Graves's disease and rheumatoid arthritis are often associated, and in this connection the relation of tetany to the thyroid gland is instructive. Tetany follows extirpation of the thyroid gland. Several cases of tetany have occurred in pregnancy in women with atrophy of thyroid.

I have seen the following sequence of events in one patient: Exophthalmic goitre, the thyroid swelling diminished, Raynaud symptoms supervened, and now she has rheumatoid arthritis. Her pulse-rate is 120 per minute, and she has tremor and proptosis. This is no isolated instance. It is far from uncommon to find the three conditions—*i.e.*, rheumatoid arthritis, Raynaud's disease, and Graves's disease—associated in one and the same individual.

The space at my disposal forbids my entering more into detail, but I cannot refrain from suggesting that in the cases with apparently atrophied thyroids, and possibly in others, some benefit might accrue from thyroid administration. The fact that Dr. Lodge ameliorated Raynaud symptoms by administering supra-renal extract is also deserving of thought, considering the frequency of concurrent rheumatoid and Raynaud; likewise an employment of lavage of the stomach, if indications point to it as the primary source of the toxæmia.

I would record my grateful thanks to the honorary physicians of the Royal Mineral Water Hospital, and especially to Mr. W. M. Beaumont, as regards the eye phenomena.

Progress of the Medical Sciences.

MEDICINE.[1]

Fat-splitting Ferment in Stomach. Of much interest is the discovery by Volhard[2] that the stomach contains a fat-splitting ferment, which, like pepsin and the rennet-ferment, is secreted by the fundus of the stomach. This ferment does not appear if unemulsified fats or oils are mixed with the watery contents of the stomach, but acts very powerfully on natural (yolk of egg, cream, milk) and artificial emulsions. Experiments show that the fat-splitting ferment corresponds entirely to pepsin and rennet-ferment, in its relations to acids, alkalies, &c., and follows the same changes in diseases of the stomach.

Influence of Foods on Gastric Secretion. The researches of Herzen, Radzikowsky and Mark-Schnorf, at Lausaune,[3] confirm the well-known conclusions of Paulow. These researches show that some of the most generally used foods cause a flow of gastric-juice; *i.e.*, by a specific chemical action on the mucous membrane they so stimulate it that it at once begins to pour out an abundant secretion. These foods include red meats, meat-juice, broths, Liebig's extract, milk, gelatine, certain peptones, and water. The last acts only in large amount. It does not follow, however, as might be thought from the researches of Schiff, that secretion and pepsin formation always go together, are one and the same thing. This view is untenable; the substances which cause secretion of gastric-juice act through the nervous system, and have no action when introduced per rectum, whilst those which cause pepsin-formation act through the blood, and are efficient when absorbed per rectum. Herzen and his pupils have now shown that Liebig's extract acts more especially in causing secretion of juice, dextrin in formation of pepsin; *e.g.*, that these are food stuffs, which act in one only of these ways. Alcohol acts powerfully in the former, and vitellin and liver-glycogen in the latter way. These observations lead to many practical results; the physician may, according to the nature of the case, influence the quantity of gastric fluid secreted or the amount of pepsin formed. Favourable results have followed from the administration of a mixture of Liebig's extract and dextrin in suitable amounts.

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[1] For the following abstracts and references I am indebted to Schmidt's *Jahrbücher*, 1902, cclxxiii. Heft. i.

[2] *Ztschr. f. klin. Med.*, 1901, xlii. 414; xliii. 397.

[3] *Arch. f. d. ges. Physiol.*, 1901, lxxxiv. 101, 513; lxxxv. 143 respectively.

Ulcer of Stomach. v. Yzeren[1] has proved by his experiments on puppies, that section of the vagi is followed after some days by the formation of an ulcer, which conforms in every respect to the ordinary stomach-ulcer in man. He concludes that spasmodic contraction of the pyloric region of the stomach is the cause of ulcer, and that it can only be cured with certainty by removing this spasm and its causes. Instead therefore of the dangerous and, in results, uncertain operation of gastro-enterostomy, he proposes a thorough division of the pyloric muscle-fibres down to the submucosa, a comparatively simple operation, which gave good results in his puppies.

Blood-examination as a means of diagnosis between ulcer and cancer of the stomach. Rencki[2] concludes that this is of no great practical use. In the case of the red corpuscles the fall of the hæmoglobin-content below 60 per cent. is not in favour of cancer, nor does the presence of nucleated red corpuscles negative ulcer; and with reference to the leucocytosis of digestion, one can only conclude from its non-appearance that there is some stomach disturbance, the one most generally associated with it being a relaxation or insufficiency of the pylorus.

Hour-glass Stomach. Büdinger[3] remarks that in this affection the passage of the chyme through the narrowed portion can often be plainly felt, and advises operation in such cases, the proper procedure in many cases being in his opinion the resection of the pyloric segment. He reports the following case in which an hour-glass condition of the stomach was due to muscular contraction:—

In a patient, æt. 42, in whom all the symptoms of hour-glass contraction of the stomach were present, the abdomen was opened, but only slight adhesions of the organ and a scar on the anterior wall were found. As this scar was being handled, a contraction began at the greater curvature with a strong drawing in of the lower border of the stomach, which, quickly and steadily increasing, advanced towards the pylorus, and was so strongly marked in the neighbourhood of the scar, somewhere about the sphincter antri pylori, as to produce a typical hour-glass deformity of the stomach. The contraction lasted about five seconds, and then passed off; the pylorus remaining quiet. This case shows that in addition to the contracture of the proper muscle at the pylorus in ulcer, hyper-acidity, &c., and to spasm of the whole pyloric region, which may be present constantly or intermittently and cause difficulty in diagnosis by resembling a tumour, we must also distinguish a special spasm of the sphincter antri pylori.

In the cases above referred to, in which there may be difficulty in distinguishing between a growth in the pylorus and

[1] *Ztschr. f. klin. Med.*, 1901, xliii. 181.
[2] *Arch. f. Verdauungskrankh.*, 1901, 234, 392.
[3] *Wien. klin. Wchnschr.*, 1901, xiv. 36.

the false tumour formed, by persistent spasm of the pyloric muscle, Bouveret[1] lays stress on the fact that in spasm the supposed tumour may be felt to disappear under the palpating finger.

As to the allied condition in sucklings, the so-called congenital pyloric stenosis of sucklings, there is much difference of opinion, some authors attributing the condition to spasm of the pyloric muscle, others to a true hypertrophy of the pylorus, while others again hold that both of these conditions are concerned.

Cancer of the Stomach. With regard to the question of the growth of cancer of the stomach from an old ulcer, Borrmann, in his recent work,[2] out of 63 cases examined *post-mortem* did not find one in which this mode of origin could certainly be attributed to the growth. Krokiewicz[3] also, in reporting a case of this kind, says that out of 7,000 *post-mortem* examinations in Lemberg and Cracow he had not seen one instance of carcinoma originating in ulcer. On the other hand, Boekelman[4] states that in the Netherlands the transition from ulcer to cancer is so frequent, that almost half the cases of cancer of the stomach originate in this way. He thinks that the conditions are altogether different from those in cases of primary cancer of the stomach. In favour of this is the difference in the state of the whole gastric mucous membrane; in primary cancer there are extensive interstitial changes, with marked glandular atrophy; in carcinoma starting from an ulcer these changes are very much less, and hence the corresponding retention of the secretory activity.

With regard to the bacilli found in the stomach-contents in cancer, Ehret[5] thinks that the presence of very numerous thread-like bacilli, in the absence of any especially great stagnation of the stomach contents, points with great probability to the diagnosis of cancer. Schmidt,[6] discussing the bacilli, whose presence in cancer of the stomach has been so frequently observed, has found that their development is favoured by stagnation of the stomach contents, by decrease in formation of HCl and ferments, and especially through mingling of albuminous detritus and blood with the contents of the stomach. This accounts for their frequency and abundance in cases of cancer. The presence of pseudo-lactic acid bacilli may lead to mistakes. It is remarkable that luxuriant growths of the bacillus coli may be found in carcinomatous stomachs, without there being any fistulous communication between the stomach and intestine. Boas[7] draws attention to the fact that careful investigation shows that blood is much more frequently found in

[1] *Lyon méd.*, 1901, Juin 23.
[2] *Das Wachsthum u. d. Verbreitungswege des Magencarcinoms.* Jena, 1901.
[3] *Wein. klin. Wchnschr.*, 1901, xiv. 8. [4] *Ztschr. f. klin. Med.*, 1902, xliv. 128.
[5] *Semaine méd.*, 1901, Mars 6. [6] *Wien. klin. Wchnschr.*, 1901, xiv. 2.
[7] *Deutche. med. Wchnschr.*, 1901, xxvii. 20.

the contents of the stomach in cancer than is generally recognised, though very often in small amounts only recognisable microscopically. He thinks that these "occult hemorrhages" are not only of considerable value in diagnosis, since outside cancer they are only found in ulcer and in pyloric stenosis, but that they also have an important influence on the course of the disease, the bad effect of constant small hemorrhages being well known.

* * * *

Gastrosuccorhœa. Reichmann's Disease. v. Aldor[1] contends for the recognition of this malady as a disease *sui generis*. It must be clearly delimited. It has nothing in common with cases in which small quantities of fluid, often containing HCl, but never pepsin, may be found in healthy stomachs, nor with those in which there is an excessive secretion of gastric-juice in consequence of motor disturbances, nor with the periodic hypersecretion in gastroxynsis; *e.g.*, in gastric crises of tabes. There remain the not very frequent but well-defined cases in which the symptoms of severe gastric pain, frequent vomiting of large amounts, great thirst, persistent constipation, form a very obstinate malady whose nature can only be correctly diagnosed by careful and repeated examination of the stomach contents both during fasting and after meals. Treatment consists in the administration of hot alkaline saline waters, washing out of the stomach, and a careful dietary with abundant fat. Atropin is beneficial, morphia harmful.

J. Michell Clarke.

SURGERY.

The surgical treatment of chronic Bright's disease is one of the latest and most startling announcements, and if the claims of cure reported by certain surgeons are substantiated the treatment would be welcomed as a hopeful feature in the conduct of an intractable and dangerous malady.

Dr. Schmitt[2] discusses the question from a historical and clinical point of view, and his paper is an opportune *resumé* of the work that has been accomplished.

Reginald Harrison,[3] in 1896, reported some cases in which the kidney was exposed under the impression that a calculus or pus was present. The exploration, however, failed to discover any obvious cause for the symptoms of colicky pain, hæmaturia and albuminuria; but the operation was followed by a complete disappearance of all the symptoms. He attributed the symptoms mentioned to an increased intra-renal tension consequent upon congestion and inflammation within the kidney.

Doubtless this explanation is correct in some instances, as

[1] *Berl. klin. Wchnschr.*, 1901, xxxviii. 39.
Med. Rec., 1902, lxii. 401. [3] *Lancet*, 1896, i. 18.

in a case of suppression of urine associated with varicella, upon whom I unsuccessfully performed nephrotomy some months ago In other cases, however, I believe the symptoms are due to an undiscovered mobile kidney which has subsequently become fixed as a result of the tearing of the tissues accompanying the exposure of the kidney. Of such cases I have had several; and this appears to me to be the most satisfactory explanation of the disappearance of the symptoms after operation.

As a result of his observations, Reginald Harrison [1] advocated either reni-puncture or capsular nephrotomy (division of the proper renal capsule) under the following conditions: (1) Suppression of urine with alarming symptoms, as in scarlatinal nephritis; (2) Progressive signs of kidney degeneration, as shown by the persistence or increase of albumin; (3) Where a marked disturbance of the heart and circulatory apparatus arises in the course of inflammatory renal disorders. Although in these cases both kidneys are probably involved, operation upon one kidney is sufficient on account of the sympathetic connection between the two organs.

Israel,[2] who has had a similar experience in the relief of symptoms following the exploration of the kidney in cases of colic and hæmaturia where no calculus was found, explains the disappearance of the renal symptoms, though only one kidney was operated upon, by assuming the existence of a unilateral nephritis. He distinctly disavows any intention to treat chronic Bright's disease or nephritis surgically, and only attacks these diseases when the hæmaturia and colic are traceable to one side only.

Edebohls [3] noticed that patients afflicted with movable kidney and chronic nephritis at the same time were completely relieved of both conditions by operative fixation of the kidney. He concluded that the displacement of the kidney was directly responsible for the existence of Bright's disease, and, therefore, placed chronic nephritis on the list of indications for nephropexy. More recently, however, he has advanced the theory that the curative effect of nephropexy upon chronic Bright's disease is brought about by an adhesive inflammation, which in establishing collateral circulation supplies the diseased kidney with new blood-vessels. The presence or absence of renal mobility is irrelevant, and is of importance only so far as to change the method of operation: in the former nephropexy, in the latter bilateral decortication, is resorted to. Edebohls also believes that unilateral nephritis is of frequent occurrence.

Pousson [4] holds somewhat similar views and, like Reginald Harrison, attributes the disappearance of hæmaturia and nephralgia to the decrease of intra-renal tension after cortical incision.

Schmitt thinks it an occasion for regret that Edebohls draws

[1] *Brit. M. J.*, 1901, ii. 1126. [2] *Deutsche med. Wchnschr.*, 1902, No. 2.
[3] *Med. Rec.*, 1901, lix. 690. [4] *Association Française d'Urologie*, Oct., 1899.

his deductions from observations on movable kidneys. Displacement of the kidney, in common with many other local processes, may be associated with the presence of albuminuria and casts, but yet have not the significance of chronic Bright's disease.

Even if chronic Bright's disease actually exists, we should not hastily conclude that the disease has been cured because albuminuria disappears after decortication of the capsule of the kidney. The symptoms of Bright's disease are sometimes intermittent; and I have performed appendicectomy upon a patient who had suffered from chronic Bright's disease for many years, in whom the albuminuria temporarily disappeared after the operation on the appendix. It would, however, be a *reductio ad absurdum* to recommend the removal of the appendix for the relief of chronic Bright's disease.

Schmitt thinks that operation in chronic Bright's disease represents only a symptomatic and not a curative measure, and from a study of the published records formulates the following conclusions: (1) In acute infectious diseases, anuria with uræmic symptoms threatening the life of the patient can be successfully combated by capsular incision or renal cleavage, which relieves congestive swelling and excess of intra-renal pressure. Operation on one side is sufficient to bring about an abundant urinary secretion, followed by a subsidence of the alarming general features. (2) Anuria with uræmic symptoms occurring in the course of chronic Bright's disease, has been temporarily relieved in some cases by surgical procedures, but in no case has a permanent cure been thereby effected. (3) When the kidney has been operated upon directly for the cure of chronic Bright's disease, the outcome has been a failure. (4) In exceptional cases, colicky pains and hæmaturia are caused by chronic Bright's disease. Capsular incision or cleavage of that kidney to which the disturbances were traceable, has been attended by excellent results. There can be no doubt that when medical expedients have failed, surgical interference has succeeded in checking the hemorrhages and alleviating the pains, but it does not inhibit the process of chronic Bright's disease. (5) Nephropexy may cure the ailments incident to movable kidney; it may remove albuminuria, if this be the result of local irritation, consequent upon the displacement; if, however, the movable kidney is affected by chronic Bright's disease, this affliction will remain uninfluenced by operation.

From these observations it is clear that a careful selection must be made of cases suitable for surgical interference. The subject cannot perhaps be said to be definitely settled, but it is well to remember that albuminuria and Bright's disease are not synonymous terms.

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Pneumococcic arthritis is a disease of some rarity, but Herrick [1] has collected a good many cases and has brought out

[1] *Am. J. M. Sc.*, 1902, cxxiv. 12.

the chief points in its diagnosis and treatment. Herrick's observations may be regarded as an amplification of an able paper by Dr. E. J. Cave,[1] who was one of the first writers on this subject.

No age appears to be exempt, but it occurs more often in adult males. It usually arises during convalescence from pneumonia, and its clinical manifestations may be described as those common to all acute inflammations of joints. The pain varies in severity from that which is slight and has come on gradually to that which is of extreme severity and abrupt onset. The joint is tender and swollen, and fluctuation can be detected when the accumulation of fluid is great. There is also in many cases peri-articular involvement, as shown by the redness, superficial tenderness, and widespread œdema. Under these circumstances the appearance of the joint is not unlike that seen in many cases of gonorrhœal arthritis.

As regards the diagnosis in cases with much peri-articular swelling, it is to be remembered that the inflammation and the resulting abscess may be near or about the joint, and yet not involve the joint proper.

The occurrence of an arthritis during the course o a pneumonia, and especially during convalescence from the same, would naturally lead to the suspicion of a pneumococcic inflammation, especially if the patient were an alcoholic, or if his affected joint were the seat of a previous trauma or injury from rheumatism or gout; but inasmuch as an arthritis complicating pneumonia may be due to the presence of other organisms, it becomes necessary to make an exploratory puncture of the joint, and, by culture, to determine as to the presence of the pneumococcus and its degree of virulence.

The constitutional symptoms show great variation. High fever, rapid pulse, dry tongue, delirium—in a word, the clinical picture of a severe septicæmia may be present.

The pneumococcus reaches the joint through the blood current in which the organisms have been demonstrated. The factor that determines the involvement of a particular joint is not always clear, yet experimentally it has been shown that a joint previously damaged is far more likely to be the seat of the local action of the pneumococcus when it has been injected into the blood than one that has not been injured.

The changes that occur in the joint vary largely with the duration of the inflammation, and also undoubtedly with the virulence of the micro-organisms, as well as the resisting power of the body in general, and in particular the joint structures. In the acute cases often little more is seen than a synovitis with redness and swelling of the synovia, and the ordinary histological changes accompanying such a condition. The exudate varies from a serous or sero-fibrinous fluid to the more commonly found thick, yellowish pus, which contains the

[1] *Lancet*, 1901, . .

pneumococcus. More than one joint may be affected, and one joint may contain a purulent, and another a serous, exudate. In other cases, and particularly those of a more subacute or chronic character, the changes are more extensive and destructive. The cartilage may be crowded, the bone invaded, the ligaments destroyed, the tendon sheaths and muscles in the vicinity of the joint involved, so that the inflammation is a peri-arthritis as well as an arthritis In the cases of longer-standing attempts at regeneration are made, and healing may occur with more or less deformity from bony outgrowths and from the adhesions of scar tissue.

The larger joints are most often involved, and the knee is the joint most frequently affected.

The prognosis is grave—mortality, 65 per cent.—largely because of the accompanying bacteriæmia and involvement of other more vital parts of the body (meninges, pleura, pericardium, etc.). Yet spontaneous recovery occasionally follows, even where there is a purulent exudate.

The well-known fact that pneumococcic infections of other structures are often relatively benign is suggestive that the treatment in these cases might be less radical than in other cases of pyarthritis. Where, however, the fluid is purulent, Herrick thinks it wise to incise at once and drain the joint; but he thinks it questionable whether numerous drainage tubes or gauze drains, with free irrigation—in other words, whether too much manipulation of the joint—is advisable.

His conclusions are, that while the prognosis, for the reasons above stated, must always be uncertain and generally grave; and while, with pus in the joint, an early, free incision is to be advocated, it is well to remember that with serous exudate, and in a few cases even with purulent exudate, recovery has ensued either spontaneously or by the simpler measures of rest, compression, or aspiration; and he believes that in the arthrotomy, which should be done early when it is indicated, there should be as little damage as possible to the joint structures by unnecessary manipulation.

In this connection we may call to mind the well-known fact that some cases of empyœma due to pneumococcus infection are cured by simple aspiration.

JAMES SWAIN.

OTOLOGY.

The **treatment of obstinate strictures of the Eustachian tube by electrolysis** has been frequently attempted of late years, and the subject is well dealt with by Dr. Norval H. Pierce in a recent number of the *Archives of Otology*.[1]

He alludes to the fact that Cumberbatch and Steavenson published a series of seven cases so treated in 1888,[2] and that

[1] *Arch. Otol.*, 1992, xxxi. 289. [2] *Lancet*, 1888, ii. 1014.

Robert Newman in a paper published in 1898[1] also brought forward some work in this direction. Fresh impetus was given to the subject by a paper published by Duel in 1897.[2] By substituting a gold bougie for the more or less cumbersome electrodes of his predecessors, Duel greatly improved instrumentation.

Dr. Pierce has subjected twenty-one cases during the past twelve months to this mode of treatment. The electric current was taken from a circuit of 110 volts, and led through a Victor shunt-controller. From 15 to 30 volts were necessary to obtain from two to five milliampères with the negative pole attached to the Eustachian bougie, while the positive pole in contact with the sponge electrode was held in the hand opposite to the tube operated on. The gold electric bougies made by Meyrowitz were employed. Contacts lasted from three to ten minutes. Lengths of contacts and strength of current varied according to the electrical resistance of the patient and the resistance offered to the passage of the electrode in the tube and the subjective sensations of the patient. Both the plain rubber catheter and the silver catheter were used. The silver catheter insulated by means of rubber tissue is more easily kept clean and more readily adapted, by bending, to the peculiar topography of each case, than the rubber catheter. The procedure was nearly always carried on under cocaine, all active inflammatory processes having been first allayed, and the strictest cleanliness observed.

Ten cases were in the class of oto-sclerosis, or rarefaction of the labyrinthine capsule. Eight were catarrhal. Of the remaining two, one was due to disease of the nervo-muscular apparatus of the tube, the other was one of almost complete obliteration of the membranous portion, due to syphilis.

All the cases had been treated by other methods before treatment was begun with the electrical bougie. Before beginning with the electrical treatment, all the tubes were explored by means of a celluloid bougie. In six of the cases of oto-sclerosis the bougie was arrested at about the isthmus. In two of these six cases, the electrical bougie passed through the osseous portion after the fourth sèance. They were all treated for two months, at intervals of a week, with catheterization every other day. In none was audition improved to a noteworthy extent. In six of the eight cases of catarrhal disease, the bougie was arrested from 4 to 23 mm. from the pharyngeal opening. In five of them, after four months' treatment, the electrical bougie failed to pass further than the isthmus, or a few millimetres beyond. In two cases in which the bougie passed directly into the middle ear, there were extensive adhesions between the tympanic membrane and the promontory. In none of these cases was there any improvement—that is, further than the improvement gained by the other methods of treatment previously pursued, nor was

[1] *Med. Rec.*, 1898, liv. 870.

[2] *N.Y. Eye & Ear Inf. Rep.*, 1897; quoted by Pierce, *loc. cit.*

there any alteration in the adhesions. The case of syphilitic stenosis remained unchanged. In only two of the twenty cases could any results be ascribed to the electrical bougie. These were both cases of subacute disease with recurrent attacks of defective audition and tinnitus with diminishing intervals. In these cases there were, in all probability, soft infiltrations in the membrano-cartilaginous tube near the isthmus. In both of them the benefit to audition and the subjective symptoms was marked, immediate, and lasting, and these results were obtained after the usual methods of injection, the catheter, inflation, and massage, had ceased to benefit.

Occasionally, in other cases, marked improvement to audition was observed immediately after the application of the electrode, but this cannot be ascribed to the influence of the electricity, inasmuch as we occasionally observe as great improvement following the use of the ordinary celluloid bougie. The explanation of this phenomenon is difficult, but probably takes place by way of reflex stimulation of the nervous apparatus of the ear.

Dr. Pierce found the electrical bougie rather painful. The use of the wire bougie in the Eustachian tube is not without danger. Several instances of acute otitis media have followed its use. There have been instances where the electrical bougie has broken off in the tube, and owing to the proximity of the internal carotid artery other accidents may occur from the accidental wounding of a blood-vessel. He comes to the following conclusions:—(1) In oto-sclerosis, electrolysis is useless; (2) In the great majority of cases of catarrhal disease, it has no advantages over other methods of treatment; (3) In a certain few cases where there is probably a soft exudate near the isthmus, it may be regarded as of some value.

W. H. HARSANT.

LARYNGOLOGY AND RHINOLOGY.

Direct endoscopy of the trachea and bronchi. Direct inspection of the bladder, and of the œsophagus and stomach, has become generally recognised as affording valuable aids to the diagnosis and treatment of diseased conditions of these cavities; but till very recently direct endoscopy of the trachea has presented insuperable difficulties. By Killian's method[1] of passing a long straight tube of sufficient length and a width small enough to get through the rima glottidis, the whole of the trachea (tracheoscopy) and of the right and left bronchus (bronchoscopy) can be directly inspected. Moreover, Killian has devised slender tubular forceps and blunt hooklets, which can be passed down the inspection tubes so as to seize and remove foreign bodies that may have become impacted in the air passages.

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[1] *Brit. M.J.*, 1902, ii. 569.

Bromide of ethyl anæsthesia. As a general anæsthetic for operations on the nose and throat, which affords a longer period of insensibility than nitrous oxide, while avoiding the dangers and inconvenience of ether or chloroform, anæsthetics which are especially undesirable in procedures involving considerable hemorrhage in the upper respiratory tract, **bromide of ethyl** is worthy of a more extended trial than has yet been made of it in this country. In America and in France it has been largely used by laryngologists, and the favourable experience of Brown Kelly[1] with this anæsthetic will lead others to use it in suitable conditions. He reminds us that it was discovered so long ago as 1827 by Serullas, and was first used as an anæsthetic by Nunneley, of Leeds, in 1849. Kelly states that the chief characteristic of bromide of ethyl as an anæsthetic is its strikingly rapid yet transient action. A suitable dose in about a minute produces unconsciousness, lasting on an average one to two minutes, from which the patient awakes and regains almost at once his normal state. But it is very important to use only unadulterated bromide of ethyl, which is transparent and colourless, with an agreeable chloroform-like odour; but exposure to light and damp is prone to cause it to decompose. Being a vaso-dilator, and having no tendency to produce syncope, it may be administered with the patient seated; but like nitrous-oxide bromide, ethyl anæsthesia is often accompanied by spasmodic closure of the jaws, and therefore a mouth-gag should be placed in position before its administration. A suitable dose (for children under three years of age average one-and-a-half drachms; between three and twelve years, two to two-and-a-half drachms; young adults, two-and-a-half to three-and-a-half drachms) should be measured out, and the whole quantity poured upon a folded piece of lint, which must be closely applied to the mouth and nostrils so that air does not enter at the sides. A slight struggling often occurs after the first few inspirations. In about one minute, more or less, the breathing becomes stertorous, and the patient should be ready for operation. In some patients who breathe slowly, or who after a few respirations cease breathing, it may be necessary to administer the anæsthetic for a slightly longer period, or to give a breath of air, or to otherwise encourage more free respiration. Kelly states that the face becomes congested, the eyes remain open, the conjunctivæ injected, and the pupils widely dilated. In adults, excitement caused by the drug is an objection, and is sometimes considerable and even violent during the brief period of recovering consciousness. Vomiting occurs in a large proportion of patients, sometimes during, more usually after, the period of anæsthesia. Several deaths have occurred from its use, and the respirations should always be watched during administration. The drug is not recommended for prolonged anæsthesia.

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[1] *Ibid*, 588.

Measurements for operating distances in the nose. The difficulty of determining the distances from the nasal orifices of the various intranasal structures and ostia is often a matter of serious moment, especially when the nasal passages are more or less occluded by pathological conditions for the relief of which operative treatment is essential. Mosher[1] has done useful work by measuring these distances in fifty-four half-heads (representing at least fifty different heads) in order to get an idea of the operating distances in the nose, the measurements being made on wet specimens. He gives three figures for each measurement, the first in the table appended being the measurement occurring the greater number of times (not the mathematical average), the second and third rows being the maximum and minimum measurements. In all cases the measurements were made from the lower edge of the posterior rim of the nasal opening; vertical measurements were made close to the junction of the septum and the cribriform plate.

	Inches.		
To the upper end of the infundibulum ...	2	$2\frac{1}{4}$	$1\frac{3}{4}$
,, ostium sphenoidale	$2\frac{1}{2}$	$2\frac{3}{4}$	$2\frac{1}{4}$
,, posterior wall of the sphenoidal sinus	3	$3\frac{3}{4}$	$2\frac{1}{2}$
,, lower border of the anterior wall of the sphenoidal sinus	$2\frac{1}{4}$	$2\frac{5}{8}$	2
,, ostium maxillare	$1\frac{1}{2}$	$1\frac{3}{4}$	$1\frac{1}{4}$
From the upper end of the infundibulum horizontally forwards to the root of the nose	1	$\frac{3}{8}$	$\frac{1}{2}$

From measurements on the cleaned skull and in wet specimens, it appears that in wet specimens and on the living one-eighth to one-quarter of an inch has to be added to the measurements made on the cleaned skull.

The lower opening of the lachrymal duct beneath the inferior turbinate is about two-thirds of the way to the opening of the antrum. This makes the average distance one inch.

Another point of considerable importance was noted; viz., that if a burr is entered at the upper end of the infundibulum and passed directly upward in order to open the frontal sinus, it will in the majority of cases enter the cranial cavity. This, Mosher states, is due to the frequent sharp slope forward of the posterior wall of the sinus. In order to enter the sinus from this point, the burr should point forward at an angle of forty-five degrees, and would have a working distance of half an inch. In order to bore straight up into the sinus, the probe must be held parallel with the teeth and close to them.

Again, it was found that in a majority of the specimens examined, a line passed one-quarter of an inch above the

[1] *Ann. Surg.*, 1902, xxxvi. 554.

lower rim of the orbit, and carried horizontally backward, passed through the ostium maxillare; a line one-quarter of an inch below the rim cut the lower opening of the lachrymal duct; a line one-half of an inch below the rim passed through the upper opening of the Eustachian tube. Fifty cleaned skulls gave the level of the cribriform plate as the mid-point of the inner wall of the orbit, and wet specimens showed that this point is one-eighth of an inch above the inner canthus of the eye.

P. WATSON WILLIAMS.

Reviews of Books.

The American Illustrated Medical Dictionary. By W. A. NEWMAN DORLAND, M.D. Pp. 770. London and Philadelphia: W. B. Saunders & Company. 1900.

The English-speaking practitioner has no ground for complaining that his philological needs are neglected. On both sides of the Atlantic medical dictionaries are issued with almost perplexing frequency, varying from the traditional "vest-pocket" booklet to the portly volume for which it is difficult to find accommodation on an ordinary shelf. In size Dr. Dorland's compilation occupies an intermediate position, and ought to be extremely popular, not only for that reason, but also for its general trustworthiness. It is more than a mere word-book, often giving an account in detail of the symptoms or signs of a disease. The "anatomic" tables, as Dr. Dorland calls them, are specially useful, and are embellished by some very helpful coloured plates. Many of the other subjects are elucidated by appropriate and sufficient illustrations, coloured and otherwise. Bacteriology in its various aspects is very fully considered. The work, presented in a very attractive dress, reflecting great credit upon printer and publisher, is one the purchase of which no doctor will ever regret.

Encyclopædia Medica. Under the General Editorship of CHALMERS WATSON, M.B. Vol. X. Pregnancy to Scarlet Fever, Pp. vi., 516. Vol. XI. Sciatica to Syncope, Pp. vi., 530. Edinburgh: William Green & Sons. 1902.

Two further volumes of this great work, previously noticed by us (*vide* Vols. xvii., xviii., and xx.), are bringing it near to a completion. Two articles, Pregnancy and Puerperium, form a large part of the tenth volume, and it is in accordance with the fitness of things that much space should be devoted to the

consideration of these processes in which we have all played an important part.

Complications of pregnancy are apt to be overlooked by the indifference with which most of us regard that which is too often considered to be a mere physiological incident, and it is well that doctors should be reminded of the desirability of a much more systematic enquiry into the pregnant woman's condition than is usually practised. The array of possibilities here recorded is truly appalling, and might easily and unnecessarily alarm the tyro in the art if he is not aware that many of the conditions described have little interest beyond that which is academic and curious. In the same paragraph in which Dr. John Phillips states that "the presence of albumin to a small extent is found in a considerable proportion of pregnant women" it is a relief to find that the "considerable" proportion is 2 to 4 per cent. In the description of the oncoming of symptoms of albuminuria there is, associated with a scientific distinction of para-globulin and serum-albumin, a touch of pathos—"a working-woman will often complain of inability to thread her needle." Is this symptom limited to persons in the class of life mentioned? If so, it seems to be a specially hard dispensation of Nature, as the working-woman will probably have more difficulty in preparing for the coming event than one who is more fortunately placed in life so far as this world's goods are concerned. The treatment of the commoner forms of difficulty is well described. The writer, whilst dogmatic as to the line he himself follows, states very fairly the reasons which lead others to adopt a different course.

It is difficult to see on what grounds Dr. A. E. Giles, in his article on the Physiology of the Puerperium, recommends a vaginal douche to correct the offensiveness of the lochia. If any irrigation is necessary it should be applied to the source of the trouble, and not merely to the channel through which the discharge passes. Dr. Giles rightly considers that too much importance is often attached to immediate intra-uterine douching. Only in very exceptional cases is it necessary, and the uterus and its owner are all the better for rest after labour is over. To correct any trouble which may arise from absorption from laceration of the vagina or its outlet we find that nothing is better than the introduction of a pessary of twenty grains of iodoform night and morning for the first three days and once a day afterwards for a week. The fear of opium for after-pains Dr. Giles unduly magnifies. His observations about diet are particularly sane; but one wonders why "the patient may be transferred to a couch as early as the tenth day," when he says that "it is an advantage for her to remain in bed for a full fortnight." Thirty-two pages are devoted by Drs. W. J. Smyly, J. Haig Ferguson, W. Fordyce, and G. R. Wilson, to the consideration of the Pathology of the Puerperium, and all should be studied with care. Much was expected from the use of

anti-streptococcic serum, but Dr. Smyly states that "the majority of authorities have reported unfavourably upon it."

In the bibliography it would have been more satisfactory if the names of the writers had always been given. For instance, in that of Diseases of the Fœtus, the name of Dr. Ballantyne is not mentioned, although reference is made to many of his valuable communications.

Various articles on skin diseases form a large part of the eleventh volume.

The article on Sclerema Neonatorum attempts to clear up the confusion which exists between this affection and Œdema Neonatorum—both extremely rare in this country. They both occur at or soon after birth; but in the former there seems to be no pitting on pressure, in the latter there is. They both consist of induration of the connective tissues: the first is invariably fatal, the second not quite so hopeless. They both point to great depression of the vital organs.

Sclerodermia, again, of which the keloid of Addison is one variety, presents many symptoms resembling the two above affections; but these cases, although they may occur in early life, do not affect infants under 13 months.

The earliest case of Scleroma occurred at the Stockholm Hospital, and is related by Usenbenzius (A.D. 1718). The child was born at eight months—the midwife said—alive, but died soon afterwards. The description of the case had the graphic title—"Fœtus vivus, frigidus et rigidus."

The "Anatomy and Physiology" of the Skin are comprised in twelve concise and well-arranged pages. The six following pages, on "Bacteriology of the Skin," contain about everything that is known on this subject; but a great deal of this can only be conjectural. No doubt a great many germs are specific, but a great many are only the residents on eligible breeding-grounds. Yaws affords a good example (p. 142): "Several micro-organisms have been isolated in association with the lesions of Yaws, and have been regarded as specific by those who have described them; but specific characters have not been definitely established. Among these are a *yeast* (Powell), a *bacillus* (Breda), and a micro-coccus (Nicholls and Watts).

Regarding the diagnosis of Lupus, we can speak with great confidence of the value of the diascopic method of Unna. This glass-pressure of the skin—with varying appliances—is unquestionably of great service. "Kerion" of the upper limbs in adults—rare affection, but to be noted—seems to be produced by the tricophyton megalosporon ectothrix, which is a pus producer on its own account, and therefore needs no pus cocci. Tinea nodosa is well described—a rare affection of the hairs of the moustache and beard—the spores are arranged at right angles to the hair shaft. Melanin, according to Leslie Roberts, on Pigmentary Diseases of the Skin, plays a very important part. It consists largely of carbon—and is free from iron—and herein

differs from hæmo-globin. Facts favour the idea that the epithelium is a complementary organ to the pigment secreting supra-renal organs. The remedy for Leucoderma, if there is one, has still to be found. Skin-grafting and allied proceedings are well and concisely dealt with.

Smallpox (pp. 212—238), by Dr. Hope, Medical Officer of Health for Liverpool, is well described, without being too verbose, and the photos, temperature charts and tables are useful; but there is little said about the hemorrhagic form. It certainly does seem that the poison of this disease is perhaps more contagious than any other infectious disease, and it persists after life has ceased — the cadaver unquestionably contains or exhales the virus.

In the article on Snake-Bites, the venom of the cobra is described, and the sp. gravity of it stated to be 10.50; surely this must be an error in printing, 1050 being meant.

An interesting article by Dr. Hyslop, on Sleep and Somnambulism, is followed by one on Sleeping Sickness or Negro Lethargy. This curious malady is described by Dr. P. Manson, C.M.G.

A Manual of Medicine. Edited by W. H. ALLCHIN, M.D., F.R.C.P., F.R.S. Vol. III. "Diseases of the Nervous System." London: Macmillan and Co. 1901.

The review of this excellent volume is long overdue, but a brief reference to its good qualities cannot be omitted. It is well up to the standard set in the two earlier volumes. There is perhaps more excuse here for the large proportion of the Editor's limited space, which is taken up by chapters on Anatomy and Physiology. Indeed, Sherrington's introduction to the Physiology of the Nervous System is so condensed that, able as it is, the meaning and importance of the statements are not always apparent to the average reader.

Dr. William Aldren Turner occupies about a quarter of the book with articles on the Neurone in relation to Disease of the Nervous System and Organic Diseases of the Brain and Membranes. These subjects are beautifully arranged, and tabulated in a helpful manner. Indeed, one of the chief features of the volume is the excellent way in which recent pathology is employed to explain the relations of the various affections of the nervous system to each other, and the care with which the differential diagnosis is worked out. The classification of acute meningitis follows that of Osler; but the writer confesses the difficulty of choosing a satisfactory arrangement, and has to go over some subjects which have been already treated in an earlier volume. Some readers may perhaps object to the statement that the most common cause of embolism is pyœmia with ulcerative endocarditis, though it is certainly an important one. An interesting article of some

length is that by Collier on Defects of Speech, which are carefully classified, and their causation is well worked out. After two more chapters on the Morbid Anatomy of the Cord and the general symptomatology, we get Dr. Ormerod's discussion on Diseases of the Substance of the Cord, divided into system and non-system ones. The motor paralyses are grouped as spastic with degeneration of the upper neurons, and placcid from affection of the lower one.

Epilepsy, hysteria, and chorea, will be found some of the most interesting articles in the section on Functional Diseases. We notice that Poynton and Payne's recent explanation of rheumatic chorea is mentioned as an important advance in a difficult subject.

It seems a pity that two articles on Medical Ophthalmology and Electricity should take up space which would have been well devoted to more detailed accounts of various diseases; but it must be confessed that wonderful skill has been exercised in framing such clear and instructive descriptions of each disease. The fact that certain affections generally grouped together are broken up into separate headings makes the descriptions seem briefer than they really are.

The Mental Functions of the Brain. By BERNARD HOLLANDER, M.D. Pp. xviii., 512. London: Grant Richards. 1901.

In many ways this is an able book, and affords abundant food for thought and reflection. Some portions of the work are extremely interesting, especially those dealing with the early history of phrenology, about which the medical profession is undoubtedly too ignorant. The author has done good service in pointing out the debt we are under to Gall, the pioneer in the modern study of the anatomy and physiology of the brain, and an observer of the first rank in this field. He seems to have been a thoroughly scientific investigator, of extraordinary industry. Some of the plates reproduced from his great work are extremely good. There is good reason to credit Gall with the first clear description of aphasia, and of the exact part of the brain involved in this disorder. This was a discovery of no mean order in the state of knowledge at that time, and there can be no doubt that the study of the different forms of aphasia has thrown more light on the workings of the brain, and on the localisation of its functions, than almost any other. Gall made many other discoveries in the structure of the brain, of first-rate importance, and showed a really scientific mind in his indefatigability in collecting facts, and in his caution in forming theories from them. Unfortunately, the extravagant inferences of his followers, which appear to have never been countenanced by him, threw discredit on his researches, which, indeed, were in themselves so far in advance of his time, that it is not surprising that they met with strong opposition. The later

absurdities of professional phrenologists still further obscured the value of his work: but it is to be hoped that at length due recognition, though so long delayed, will be awarded to him for the extent and value of his researches. The story of Gall's life should be a stimulus to every worker in science, as showing that, though sometimes long delayed, the value of good, honest work, must inevitably one day be recognised.

Whether the author is wise in seeking to revive the term "phrenology," seems to us doubtful: it has now so long been associated with pseudo-scientific "Professors," and in the popular mind with "bumps," that its rehabilitation in a better sense is practically impossible, and indeed is unnecessary, for we have in localisation of brain functions a term which, although cumbrous, is well understood, and has no such sinister connections.

After the discovery of the speech centres, that of the motor areas has been the most fruitful in advancing the knowledge of brain localisation. The study is one, however, of extraordinary difficulty, partly owing to the great complexity of the structure of the brain. Although the unravelling of this structure has proceeded apace during the last twenty years, due to improved methods of investigation, there is still a vast amount to be done; and until we have a far more exact knowledge of anatomy, we cannot advance far on the lines of differentiation of function.

That there must be localisation, or rather specialisation in the brain, to an extent unknown in any other organ is obvious from what we already know of it; indeed, it would be extraordinary if the most highly specialised organ in the body did not show the most advanced differentiation. Meanwhile, clinical observation on the effects of disease should form a most valuable aid to this study, and is capable of being much more utilised than it is at present. To be of permanent value, however, such observations must be exact, and in every case supplemented by *post-mortem* examination, which must include a careful microscopic study of the parts affected. To take, for instance, the case of tumours: no case of brain tumour can be safely utilised for purposes of localisation unless it is well circumscribed, exactly limited to one portion of the brain, and its effects on neighbouring tracts microscopically investigated.

In this book cases are inserted which are not full enough in clinical detail, are wanting in a *post-mortem* examination, or in which the pathological lesion was an extensive one. Such cases are of little value in an argument of the present kind.

A section of the book is taken up by an attempt to considerably extend the positive results hitherto worked out in brain localisation, by assigning certain forms of insanity to lesion of a special cerebral area for each. The author has collected a considerable body of evidence in favour of the localisations he brings forward for these diseases. Bearing in mind, however,

that such localisations differ in kind from those now established by experiment and pathological observation in recent years, it is, perhaps, best at present to leave the question an open one. To make the position certain, the converse proposition, that those affections are never met with as a result of lesions of other parts of the brain, should be dealt with.

Further, it may be pointed out that if such cases can be definitely localised, they will not necessarily be coterminous with the external (anatomical) markings of the cortex.

We have said enough to indicate that the book may be read with profit by all medical men, that it will be found extremely interesting, and that the problems suggested by its perusal will stimulate thought, and lead to further endeavours to extend a branch of knowledge in which the near future promises a considerable advance.

Aids to Materia Medica. By WILLIAM MURRELL, M.D. Three Parts. Pp. 91; 133; 94. London: Baillière, Tindall & Cox. 1898—1900.

In primis the reviewer begs to apologise to the author and publishers for the delay which an accidental circumstance has caused in the appearance of this notice of a most useful and commendable work.

In Part I. we have a complete and excellent synopsis of the uses and actions of the official inorganic *materia medica*; brief but clear statements about such accessory methods of treatment as clothing, baths, bleeding, and such like, and, in addition, a consideration of many general topics, such as prescribing, the alterations in the last edition of the *British Pharmacopœia*, and other matters.

Part II. is devoted to the consideration of drugs of vegetable origin. These are adequately but not too fully treated for the purposes of the medical student. The English language is not very well adapted to precise expression, and we have noticed some important sentences which are not devoid of equivocal meaning, caused perhaps by too great a desire to administer the instruction in the *materia medica*, "like pills, in the smallest possible compass," as the author humorously remarks in the preface. Is it the experience of most practitioners, that strophanthus "produces no gastric disturbance?" It certainly acts as an aperient when administered for some few days successively.

Part III. gives an excellent and sufficiently full account of synthetical products, drugs of animal origin, and serum therapeutics. We would desire to speak very highly of this section of the work; it is most attractively and pleasantly written, and tells all that a student needs to know of this branch of *materia medica*, both official and extra-official. We perused the book with advantage, and wish every student would do the same, and so mitigate the present deplorable ignorance

on the part of medical students about drugs and all other non-surgical therapeutical measures. Does *sweet briar* form to the Englishman's mind an accurate translation of "*Betula lenta*" (p. 26)?

Lectures on Chemical Pathology. By C. A. HERTER, M.D. Pp. xv., 461. London: Smith, Elder, & Co. 1902.

In publishing these lectures, which were delivered at the University and Bellevue Hospital Medical School, New York, the author hopes they will prove useful to students and practitioners of medicine who have not had the opportunity of keeping in touch with modern research in the field of chemical pathology. The opening chapter on the chemical defences of the organism against disease gives, on the whole, an excellent summary of present-day theories on these questions; we regret, however, that the work of Metschnikoff and the Metschnikoff school of investigators obtain so little notice in this section, being dismissed in a few lines.

The chapters on the chief food-stuffs and their fate in the body in health and disease; excessive fermentation in the digestive tract; the chemical pathology of gastric and intestinal digestion and of hepatic disease, are highly instructive; but the best section of all is, we think, that on diabetes.

While remembering that there are other excellent works dealing with these subjects, we cordially welcome this as an eminently scientific and most readable summary of recent investigations on chemical pathology.

Cancer of the Uterus. By THOMAS STEPHEN CULLEN, M.B. Pp. xvi., 693. New York: D. Appleton and Company. 1900.

This volume is a welcome addition to the literature of gynæcological pathology. The plates and illustrations are most clear and very thoroughly described, and being in a large number of cases the result of photo-micrography, are free from the diagrammatic defects which it is difficult to avoid in drawings. The author gives a short resumé of the ways in which his material was obtained, and an interesting account of the technique of his methods of preparation. According to his description, his *rapid* method allows of the identification of a specimen fifteen minutes after its excision; the advantage to the patient gained by such a rapid confirmation of a diagnosis is obvious, even if the microscopical evidence only adds one more point to the completion of a diagnosis probably already more than provisional. We think the author is perhaps unduly optimistic as to the powers of the microscope as a diagnostic agent in these cases: we cannot imagine in practice an accidental or casual positive microscopical diagnosis being allowed to weigh against clinical

signs. We have had personal experience of cases in which such a diagnosis has proved faulty in the light of subsequent clinical history; in two cases at least in our knowledge, patients in whom apparently conclusive evidence of the existence of malignant disease was given by microscopical sections, have survived without further developments for six and nine years respectively.

Unless the author's methods are far more complete than those in vogue with us, we should hesitate before accepting microscopical evidence, especially negative evidence derived from uterine scrapings, as conclusive unless backed by negative clinical evidence.

In addition to the pathological descriptions, operative procedures are very fully described, and interesting tables are given; chapters which will well repay perusal are those on symptomatology, prognosis, and etiology. As regards the last, the author, on the whole, is inclined to discount heredity: he considers traumatism, as evidenced by the frequent occurrence of squamous carcinoma of the cervix in parous women, an important factor, and does not consider that emdometritis is a distinct cause. Traumatism, in his opinion, does not play any large part in the causation of carcinoma of the corpus uteri.

We can only repeat that this work will be of the greatest assistance to every student of uterine pathology.

Introduction to Medical Jurisprudence. By WILLIAM MCCALLIN, M.B. Pp. vii., 151. London: Baillière, Tindall & Cox. 1901.

This volume may be useful as a first introduction to larger works, or to enable a student to revise what he has read; but taken alone it can give very little instruction. It is written in too good a style for an epitome, and what it says is accurate, and the work of a man who knows his subject. Moreover, it has some paragraphs which are too often absent in larger works: such as that on the legal status of the medical practitioner, and on gifts to medical men; but a hundred and fifty pages of good-sized print cannot possibly suffice to expound the subject matter. No one without other knowledge could understand or act upon many of the statements; for instance, what is "full apprehension and actual danger of death, which ensues," in the definition of a dying declaration? It is quite true, but useless for guidance. The courts have actually rejected a declaration, which stated that the person had "no hope of recovery at present," as insufficent. Moreover, there are practically no references, so that it is impossible to refer to the statute or authority on which such statements are based. We cannot help regretting that so able a writer has not found time to make a better book.

A Manual of the Diagnosis and Treatment of Diseases of the Eye. By EDWARD JACKSON, M.D. Pp. 604. Philadelphia and London: W. B. Saunders. 1900.

The chief feature in which this admirable manual differs from other text-books is the very practical way in which each subject is dealt with, and the furnishing of a bibliography at the end of each chapter of the best and most accessible works of reference upon that subject. With so limited a space, the author has naturally had to treat some of the diseases rather briefly. He has, however, found room for a most useful chapter on "Ocular Symptoms in General Disease," and for twenty-two pages on "Remedies and their Applications." The illustrations are not elaborate, but they are numerous, clear, and to the point. The book is thoroughly up to date, and there is no lack of reference to new operations and new drugs. A very full table of contents, and a most complete index, make it a very handy manual for reference, and we can very confidently recommend it to the general practitioner and student of ophthalmology.

Original Contributions concerning the Glandular Structures appertaining to the Human Eye and its Appendages. By ADOLF ALT, M.D, Pp. 23, and xxxvi. plates. St. Louis: *American Journal of Ophthalmology*. 1900.

No excuse for the publication of such admirable work by Professor Alt is needed; and as he points out that the old operation of removal of the lachrymal glands for incurable lachrymation has now become a legitimate surgical procedure, his investigations become of practical interest. Besides the orbital lachrymal gland, he describes most minutely the palpebral lachrymal gland separated from the former by the levator palpebræ superioris and Müller's non-striated muscle. This little gland, or group of glands, extends a variable distance towards the nasal side of the upper lid, and round the external canthus into the lower lid. These glands do not, as is usually described, open into the duct of the orbital gland, but into one or more ducts for each part of the group. He also finds that there is usually a pair of very small similar glands, one above and one below the caruncle. These facts, and numerous other minute details relating to the glands of the lid margin, are substantiated by sixty-eight photomicrographs, which are in every instance unusually good.

Elementary Ophthalmic Optics. By J. HERBERT PARSONS, B.S., B.Sc. Pp. 162. London: J. & A. Churchill. 1901.

This book is intended to be used in conjunction with some other text-book on the refraction of the eye. Its subject is thus divorced to a certain extent from its practical application, and the usefulness of the work is likely to suffer in

consequence. The first five chapters are devoted to the laws of reflection and refraction, and the information contained in them is hardly more easy to understand than that to be found in the ordinary text-books on optics. The chapter on ametropia is of much practical value, containing as it does explanations of the advantages of the proper position of spectacle lenses with relation to the cornea, and of the difference in the size of the retinal image in hypermetropia and myopia, with the consequent difficulty in prescribing lenses for anisometropia. The chapters on the ophthalmoscope and retinoscopy show evidence of great care in arrangement and minute attention to details. As an example of this we would refer to the explanation of the shadow margin in retinoscopy. The table of contents is very brief, and there is no index. For purposes of reference this is a distinct disadvantage; but the omission is to a certain extent compensated for by printing all the more important propositions in italics.

The Practitioner's Guide. By J. WALTER CARR, M.D. Lond., F.R.C.P.; T. PICKERING PICK, F.R.C.S.; ALBAN H. G. DORAN, F.R.C.S.; and ANDREW DUNCAN, M.D., B.S. Lond., F.R.C.S. Pp. vi., 1107. London: Longmans, Green & Co. 1902.

The authors have endeavoured, as far as possible, to make this book what its title suggests that it is—a Guide to the General Practitioner, and they have devoted the space at their command to a description of those subjects which they believed would be useful. It does not profess itself to be a complete Encyclopædia in one volume, but it certainly is a handy reference book for the busy man, and being in Dictionary form any topic is easily found. An index of seventeen pages also adds to its utility as a ready-reference book for consultation at odd minutes. The names of the authors are a sufficient guarantee of the reliable character of the work.

The value of such a book is no doubt mainly in the direction of refreshing the memory upon various little points forgotten since the time of reading more systematic works. It will give practical aid, and often also a concise summary of the more scientific aspects of disease. At the same time books of this character can rarely be considered to speak authoritatively on all points. There will be many who will differ from such a statement as that which says, "high arterial tension kept up by 'over-eating, over-drinking, and constipation,' is particularly apt to lead to adhesions of the cusps, and so to mitral stenosis." We should also differ from the view that the strain thrown upon the tricuspid valve in cases of emphysema of the lungs "may lead to the supervention of chronic and inflammatory changes" in the valve. Little blemishes of this character do not, however, seriously detract from the value of the work.

Ligaments: their Nature and Morphology. By J. BLAND-SUTTON. Third Edition. Pp. viii., 112. London: H. K. Lewis. 1902.—We are glad to find that a third edition of this excellent work is now issued, as it is one of those books that all "students" (in the true sense of the word) will take a delight in reading. It is only a few years ago we favourably reviewed a former edition (*vide* Vol. XV., p. 344); our opinion on this subject remains unaltered. The only fault we have to find with the volume is that its fascinating pages are too few in number.

Acute Dilatation of the Stomach. By H. CAMPBELL THOMSON, M.D. Pp. 54. London: Baillière, Tindall & Cox. 1902.—This is an interesting monograph based on a paper discussed at the Royal Medical and Chirurgical Society, and giving an account of fifty cases, either collected from the literature or observed by the author. The affection appears sometimes after operations or anæsthetics, and sometimes without any assignable cause. It is marked by a sudden onset, the vomiting of large quantities of fluid, very severe general symptoms, and often ends fatally in a few days. Hilton Fagge, in this country, Albrecht, Kundrat, and others have previously written on the subject. The author takes the view that the symptoms are primarily due to a paralysis of the nerves of the stomach, the walls afterwards becoming distended by gas or fluid. The paralysed stomach presses on the duodenum, where it crosses the spinal column so as to prevent any out-flow of its contents. There seems to be no pyloric stenosis, and the upper part of the duodenum together with a variable portion of the remainder of the intestines is generally dilated. The view that obstruction is caused by the superior mesenteric vessels compressing the duodenum is shown to be untenable. As to treatment: the stomach should be emptied by the stomach tube; hypodermics of strychnine and rectal feeding are recommended; while to relieve the compression of the duodenum, it is advisable to turn the patient on the right side or into a prone position, and even, if he is strong enough, into the knee-elbow one. Saline injections, to make up for the loss of the vomited fluid, may be needed; and the prognosis is usually bad whether or no surgical treatment is attempted. The writer thinks, however, that probably only the severe cases are noticed, and that mild ones may often occur and recover.

Obstinate Hiccough. By L. F. B. KNUTHSEN, M.D. Pp. viii., 169. London: J. & A. Churchill. 1902.—The title of this book fully describes its contents. Collections of cases from the British and foreign journals, with cases quoted from various text-books on medicine and extracts from various reviews, make up a pretty large volume, well printed on the lightest of paper, and easy to read when it is necessary so to do. It forms a graduation thesis, which gained honours. Four types are described: the Inflammatory, the Irritative, the Specific, and the Neurotic; and three pages of drugs and methods which have proved successful are

given at the end. To those who may be called upon to treat any of these somewhat rare cases of intractable and persistent hiccough, a perusal of this cannot fail to be of assistance. The author emphasises the necessity for a careful investigation and a knowledge of the cause of the hiccough before we can expect any permanent benefit from the very numerous modes of treatment at our disposal.

Medical Ethics: a Guide to Professional Conduct. By ROBERT SAUNDBY, M.D. Pp. viii., 88. Bristol: John Wright & Co. 1902.—The thorny topic of medical deontology is one on which a guide is often needful. Dr. Saundby has launched forth boldly, and his views are for the most part founded upon actual cases and the decisions which have been given in the leading medical journals during the past few years. Dr. Saundby's experience in these matters is great, and no one is better qualified to speak with the force of authority. Appended to the volume are extracts from the bye-laws and regulations of the General Medical Council and Medical Corporations relating to the conduct of members of the medical profession; these are the foundation of all medical ethics, and little beyond these is needed as a guide for daily conduct. Still, "it is not sufficient to say that medical ethics may be summed up in the Golden Rule": a book like this assists much in the application of the Golden Rule to the individual case, and Dr. Saundby's views are not narrow, inasmuch as he holds that consultation is permissible between all duly qualified medical practitioners, whether they may be called consultants, general practitioners, homœopaths, or mesmerists. The book is the result of much study, and the conclusions have in many cases been arrived at after consultation with many friends of judgment and influence. We are glad to welcome this record of experience and opinion by one who is *facile princeps* master of his subject; and although we cannot expect that everyone will accept all the views expressed, the profession will feel much indebted to Dr. Saundby for his courageous attempt to give us a standard of authority and a reliable guide through a field beset with pitfalls.

Transactions of the Medical Society of the State of New York. Published by the Society, 1902.—This volume of 528 pages is one of the most valuable works in our Exchange list. The Anniversary address, by Dr. Henry L. Elsner, of Syracuse, "On the Value to the Physician of Modern Methods of Diagnosis," is an excellent summary of recent work, and justifies the conclusion that "*the moral force of scientific methods in medicine is the greatest factor in modern medical practice*," inasmuch as "rational medicine requires for its successful practice a scientific fundament." Ten communications are each entitled "Symposium": four of these are on the physiology, the diseases, and the surgery of the pancreas; and six on hepatic diseases. Later, we find a group of four articles on general paralysis or paresis,

also called a symposium—we wonder why this word has so departed from its original meaning, "a drinking party." Medical meetings may often be convivial; but a series of dry papers is scarcely worthy of this festive appellation, especially when published in a volume of *Transactions*. We must, however, admit that the papers are for the most part of exceptional merit, and the volume is full of instruction from beginning to end.

The Johns Hopkins Hospital Reports. Vol. X. Nos. 3, 4, 5. Baltimore: Johns Hopkins Press. 1902.—This volume contains four very interesting papers. The first is on Hodgkin's Disease, by Dr. Dorothy M. Reed, with an account of the thorough microscopical examination of eight cases. The paper especially deals with the relation of the disease to tuberculosis; and the author concludes, we think on sufficient grounds, that Hodgkin's disease is a definite clinical and pathological entity. She also describes histological changes which she regards as specific. Dr. Futcher's paper on Diabetes Insipidus enters very fully into the subject, and contributes five cases. He divides the cases clinically into primary, and secondary or symptomatic, and shows that the old classification into hydruria, azoturia, and anazoturia is no longer tenable. He considers that cerebral syphilis is a more common cause than is generally supposed. Drs. Howard and Perkins give a valuable and thorough account of the origin and occurrence of eosinophil cells in normal and pathological tissues. And the concluding paper is one by Dr. Lynch on the placental transmission of typhoid fever, showing *inter alia* that the typhoid bacillus may pass from mother to child in utero, and set up fœtal septicæmia, the child dying in utero, or soon after birth.

A Manual of Medical Treatment, or Clinical Therapeutics. By I. Burney Yeo, M.D. New and Revised [Third] Edition. Two Volumes. Pp. xiii., 696; vii., 818. London: Cassell and Company Limited. 1902.—The object of this work is the study of disease from the point of view of treatment. The teaching of therapeutics is here approached from the side of the disease, and not from the side of the drug or remedy. The author points out that "it is by examining into the mode of *causation* of disease, by investigating the true nature of the morbid changes which underlie the *phenomena* of disease, and by an exact knowledge of the properties and mode of action of the agencies we introduce for the purpose of influencing favourably its course, that what are termed *rational indications* for treatment are arrived at." It is the author's aim to deduce rational indications for treatment from an examination of the pathological nature and the clinical course and character of the disease under discussion. These volumes, teeming with common-sense methods of treatment, the greater part of which are found to be more or less useful, give the lie direct to the views of the satirist, that the art of drugging consists of pouring in substances of which little is known into

bodies of which we know less. Those who use only few drugs are commonly those who have only learned to use a few; and those who boast that they rarely give drugs at all must neglect many opportunities of doing things well worth doing. Medicine is not yet out of date, and operations are not everything. Rational therapeutics, grounded on physiology and pathology, must in the long run prevail over all the artifices of the empiric and the charlatan. Our previous review (Vol. XII., 1894, p. 125) states that the book is to be commended "as a useful and practical one, based on sound scientific principles, well adapted to the needs of everyday work, and supplying a distinct want in medical literature." The appearance of the volumes of the first edition taken from our Library shows that it has been distinctly popular, and that a new edition is likely to be more so. There is no great difference in the size of the new edition, the preparation of which has been no light task; it has been needful to execute a most careful sifting in order to retain what is likely to be of lasting service, and to discard that which, at best, can only be destined to a temporary popularity. Numerous additions have been made, such as Hay Fever, Paralysis Agitans, Cerebral Tumours, Erysipelas, Cerebro-Spinal Fever, Rickets, Scurvy, and Purpura. We can only congratulate the author on the efficiency and utility of his work and on the fact that the most recent introductions have not been overlooked; for the very complete chapters on the climatic and medicinal treatment of phthisis conclude with a list, extending to nearly five pages, of sanatoria for the reception of paying patients. A general index of nearly fifty pages gives the reader every opportunity of finding the latest information on almost every variety of medical treatment.

Clinical Methods. By ROBERT HUTCHISON, M.D., and HARRY RAINY. New and Enlarged [Second] Edition. Pp. xii., 612. London: Cassell & Company Limited. 1902.—Clearness, conciseness, and accuracy are essential characteristics for any handbook on practical clinical work, and we have no hesitation in saying that these are the features of this handy manual, which will be found of very great service to students and practitioners alike. It is very complete: the authors have not allowed themselves to stray outside the proper scope of their work, and they have given throughout the book detailed instructions and practical hints which could only occur to those who are constantly in touch with students. We know of no better guide to place in the hands of those entering on work in the medical wards of a hospital, or for practitioners who desire to keep themselves well versed in the more recent developments of practical medicine.

Gibson and Russell's Physical Diagnosis. Third Edition, revised and rewritten by FRANCIS D. BOYD, C.M.G., M.D. Pp. xvii., 448. Edinburgh: Young J. Pentland. 1902.—The

third edition of this work has been largely revised and rewritten. The new sections deal with examination of the blood; examination of gastric contents; intestinal parasites; cranial nerves; and clinical bacteriology. The information given under each of these heads is essentially practical and thoroughly up to date. Of especial value is the chapter on the chemical examination of stomach contents, and the interpretation of the results obtained, but the classification adopted of the white blood cells is one which is likely to lead to confusion, and the descriptions of some of the cells, such as the myelocyte, is meagre and unsatisfactory. The book as a whole is one which can be most heartily recommended as an aid both to students and practitioners.

A Manual of Surgery. By WILLIAM ROSE, M.B., B.S., and ALBERT CARLESS, M.S. Fifth Edition. Pp. xiv., 1213. London: Baillière, Tindall & Cox. 1902.—The production of five editions of a book in four years is sufficient to show that the work has filled a definite want. The authors have wisely resisted the tendency to enlargement which so often accompanies new editions, and which thereby destroys much of their *raison d'être*. The present arrangement is sound and practical, and the volume is certainly one of the best of the smaller manuals of surgery. Some of the errors of the first edition, however, still exist. In speaking of the diagnosis of calculi by X-rays, it is stated that "phosphatic calculi are more easily detected than those consisting of oxalate of lime," and nephrorrhaphy is defined as "the title given to the operation for fixing a movable kidney." The book is not well bound.

Hydatid Disease of the Lungs. By ALFRED AUSTIN LENDON, M.D. Pp. viii., 122. London: Baillière, Tindall & Cox. 1902. —The author, since leaving Bristol to practise in Adelaide, has had ample opportunity of seeing and treating a large number of cases of hydatid disease, as this disease is so much more frequently met with in South Australia than in this country. These clinical lectures are a most useful addition to the literature of the subject referred to, and they are placed before the reader in a clear, practical manner; the cases quoted are a well-selected series, and numerous valuable hints are given with regard to the diagnosis and treatment of the individual cases. It will be wise for surgeons here to bear in mind the conclusions of the author concerning the invasion of the thorax by cysts of abdominal origin. They are these: "Short, however, of certainty, I should lay great stress (1) on the possibility of any hydatid at the base of the right thorax being hepatic in origin; (2) on the probability of any case in which a daughter cyst has been expectorated turning out to be hepatic, because daughter cysts are comparatively uncommon in hydatid disease of the lungs." The text is well illustrated, and such details as printing and paper have received so much consideration that

the result is excellent. In any future edition we would suggest that the last chapters be so arranged as to come earlier in the volume.

An Introduction to Dermatology. By NORMAN WALKER, M.D. Pp. xvi., 301. Bristol: John Wright & Co. 1902.—We had great satisfaction in reviewing this work about three years ago. It still retains its modest title; and the fact that another edition is called for under three years speaks for itself. The new edition is larger, as might be expected, containing 301 pages as against 247 in the first. The bulk of the new matter is added to bring the contents up to date, and there is besides a considerable increase in new plates, printed upon better paper, and also more illustrations of the text. We notice, with much appreciation, that the author admits the description of Herpes Zoster, or "Zoster" as it is often termed, as an "acute disease of the nervous system"; and he introduces some of Head's interesting diagrams. We were well pleased with the chapters on Eczema in the first issue, and in the present volume they are still more interesting. No doubt many of the so-called varieties of eczema will, as time goes on and knowledge increases, be relegated to their proper places, and the complications of eczema be correspondingly reduced. Some very important observations concerning seborrhœa and acne are recorded; but we cannot agree with the author that psoriasis should be classed with seborrhœa, the two present such important differences, and amongst them the comparative rareness of psoriasis of the scalp, or its insignificance generally when the scalp is affected, are not points to be lightly set aside. The book is fully indexed, and is one to be appreciated by students and busy practitioners.

The Treatment of Neurasthenia. By A. PROUST and GILBERT BALLET. Translated by PETER CAMPBELL SMITH. Pp. xiv., 213. London: Henry Kimpton. 1902.—This will be found a useful book for the medical practitioner; in it he will find a good account of the varieties of neurasthenia, and of the treatment to be adopted. In present-day practice, an increasing number of patients suffer from this disease largely as a consequence of the wear and tear of the conditions of modern life; and it is essential in treatment to have a thorough knowledge of the disease, as a fundamental point for success in treatment is to be able to enter into a sympathetic appreciation of the patient's sufferings. A great deal can be done for them by an intelligently conceived line of treatment, and from this book many useful hints in this direction may be gained.

Aids to Practical Dispensing. By C. J. S. THOMPSON. Third Edition, Enlarged. Pp. viii., 92. London: Baillière, Tindall & Cox. 1902.—This little book deals in a very comprehensive manner with the many practical difficulties of dispensing. It is doubtful whether pharmacy can ever be learnt from the pages of a book; but as an adjunct to the dispensing

counter, any student, medical or pharmaceutical, will find it useful. Giving the first chapter to general principles and manipulation of apparatus, it deals in successive chapters with the various forms of the problems set by the prescriber, not only with the mixtures, emulsions, pills, plasters, and suppositories of an older day, but including a chapter on the compressed tablets and pastilles that characterise the 20th century prescription. The paragraphs on incompatibles and pill excipients will be found very useful. Under "weighing and measuring" in chapter one, some reference might with advantage have been made to that great difficulty of the average student, the relation between weight and measure, and its application to percentage solutions prepared by English weights. Regulations for the keeping and selling of poisons, a table of solubilities, and a glossary of Latin terms—some of which, by the way, need considerable revision—complete a very useful little manual.

Merck's Index. 11 Auflage—Abgeschlossen Ende Juli, 1902. Darmstadt: EDUARD ROETHER.—This volume of 374 double pages is the second edition of the index published at Darmstadt in 1897. During the five years, ten thousand copies have been distributed. The original plan of the work has been followed, chief consideration having been given to the needs of physicians and pharmacists. The index is divided into six parts: the first comprises chemical bodies and definite principles, certain Galenical preparations and organic extracts; the second, special solutions and forms of substances used in analytical and microscopical work; the third, crude drugs; the fourth, minerals; the fifth, collections suitable to schools and museums; and the sixth, sundries. Throughout the various sections brevity and compactness have been aimed at; and to aid in this object abbreviations have been used, of which full explanations are given. In the therapeutic notes special attention has been given to dosage; the indications for the uses of remedies have been carefully revised, and in treating of poisonous bodies their antidotes have been noted.

The Pharmacopœia of the Hospital for Diseases of the Throat, Nose, and Ear. Edited by H. LAMBERT LACK, M.D., and CHARLES A. PARKER. Sixth Edition. Pp. ix., 75. London: J. & A. CHURCHILL. 1901.—This eminently useful epitome of formulæ for use in diseases of the throat, nose, and ear is brought well up to date. The pharmacopœia has been improved in several respects, especially in the addition of a series of formulæ from the most recent local anæsthetic preparations, and in the metrical system equivalents of the ingredients being appended to the British Apothecaries' weights and measures.

Christian Science, Medicine, and Occultism. By ALBERT MOLL, M.D. Translated from the German by F. J. Rebman. Pp. 47. London: Rebman Limited. 1902.—Dr. Moll is a careful investigator of hypnotism, and after reading his book on

this subject in the "Contemporary Science Series," one is a little surprised that he should take the trouble to seriously criticise so-called "Christian Science." He does this, however, in a fair, impartial manner, and in a scientific spirit. He looks upon Christian Science as a psychical epidemic, spreading along "lines of communication" like other infectious complaints, and, like them, difficult to check. Charlatanism is, however, more easily dealt with in Germany than in England, for we are told that a few years ago S—— was sent to prison for treating people with prayer and footbaths, etc. "For this performance S—— received from each of his patients eight shillings, and from the police magistrate one month." The extreme cleverness evinced by Mrs. Eddy in avoiding rational conclusions as to the effect of poison, etc., is very entertaining; and she is certainly humorous when she points out that "particular care should be bestowed upon patients who have been taking physic for some time, *and in consequence are run down.*" Dr. Moll (pp. 29 and 30) is rather too severe on specialists. He "hopes that this movement will eventually succeed in suppressing specialism, and re-establishing the general practitioner in that position to which he has a well-founded claim." He very justly notices that these people (*i.e.*, the followers of Christian Science, etc.) are easily impressed by anything which deviates from the normal rule; "thus it may not be a mere accident . . . that many spiritualists are strong believers in Dr. Jaeger's sanitary wool theory, are enthusiastic homœopaths, or strict vegetarians, are severe enemies of the regular school of medicine, and—who can tell?—perhaps also inveterate Baconites."

The Mattison Method in Morphinism. By J. B. MATTISON, M.D. Pp. 40. New York: E. B. Treat & Company. 1902.—This monograph is the outcome of thirty years' experience in the study and treatment of this disease. The method commended is a mean between two extremes—"avoiding the painful ordeal of abrupt disuse, and the tiresome delay of prolonged decrease,—and is based on the power of certain remedial resources to subdue abnormal reflex action, and secures, largely, two cardinal objects—minimum duration of treatment, and maximum freedom from pain." The drug which is to do all this is bromide; the initial dose of the sodium salt is ten grains, twice daily, the dose being daily increased up to a maximum of 100 grains twice in twenty-four hours. "Each case is a law unto itself; and the length and amount of the bromide giving, and consequent rate of opiate decrease, is determined entirely by individual peculiarity." Two other drugs, codein and trional, have their uses, and form with the bromides the main remedies on which reliance is placed. The book abundantly proves that morphinism is vincible.

Editorial Notes.

The **Medical Faculty of Univerity College** may be congratulated in its good fortune in having been able to secure the services of Sir Victor Horsley, F.R.S., F.R.C.S., at the annual distribution of prizes on October 24th, 1902. The address given on that occasion was described by Professor Nelson Dobson as "a happy blend of erudition, common sense, and eloquence." It must be encouraging to the present generation of medical students to learn that the number of men now entering the profession is fewer than it was ten years ago, and that the present is a most extraordinarily favourable time to enter it; this may be so, but it is very questionable whether the position of the medical man in our cities has in any way improved, for the multiplication of clubs and cheap dispensaries must make it very difficult for the average practitioner to secure an income adequate to the work he has had and has to do.

It was also pointed out that the activity of the General Medical Council in weeding out the evil-doers of the profession has never been recognised by the public, who are not commonly aware of the fact that the arrest of professional misconduct has been one of the most important functions of the Council, which has so won the gratitude of the profession in general by doing its best to keep up the social status at a high level. He gave also a few words of eulogium of what is commonly called medical etiquette, which he considered to be an outcome of a sense of responsibility of the life of the patient: he considered that the assumption of mystery was a kind of professional misconduct of which the State took no cognisance, but which the medical profession had endeavoured to combat for many years past. Sir Victor Horsley concluded his address by a eulogium of the students' clubs, and a desire that they might federate their sports. We are glad to learn that every effort is being made to unite all departments of the College in the athletic field, and that the Students' Clubs Union is already a success.

The same idea, unity, was also emphasised by Sir Victor at the annual dinner, which was held at the Royal Hotel in the evening, under the presidency of Dr. Michell Clarke. Sir Victor then stated that the Medical School should soon be able to grant its own degrees, and to this end it was important to combine all the central teaching bodies of the city. Many attempts to accomplish this have been made, and we hope that the time is not far distant when these attempts will be successful.

* * * * *

The Annual Meeting of the **Bristol Medico-Chirurgical Society**, to which this Journal owes its existence, affords us an opportunity of alluding to the good work done by it for a period of over twenty-five years. The recurring Presidential addresses form a series of which the Society may well be proud, and the last, which we publish in this number, is one of the most entertaining of them all.

Mr. Munro Smith was Secretary of the Society for many years, and the Presidential office is his natural due in recognition of all the good work he has done on its behalf. He was succeeded in the secretarial office by Mr. Paul Bush, C.M.G., who will also in the ensuing year be promoted to the office of President.

One of the most useful developments of the Society has been this Journal, which commenced under the editorship of Mr. Greig Smith in 1883. This number completes the twentieth volume of a work which has ministered much to the mental activity and prosperity of the medical profession of the neighbourhood.

Another good work done by the Society was the establishment of a Medical Library, and the Report of the Honorary Librarian (page 378) shows that we have an exceedingly good medical library in Bristol; this is mainly due to the persevering energy of the late librarian, Mr. L. M. Griffiths, and the work is being well maintained by his successor, Mr. C. King Rudge. The story of the genesis of this library was told in the *Journal*, vol. ix., pp. 313–6, and it seems necessary to remind the members of the Society that "the library is the direct outcome

of the success of the *Journal*: if it is to increase its efficiency, it must do so to a very large extent by the members of the Society extending in every possible way the circulation of the *Journal*, and by their own contributions raising more and more the literary standard of the publication." Some further details of the growth of the Library since the year 1901 will be found on page 376.

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The work of book reviewing has always been an important part of the functions of this *Journal*. These reviews are commonly written by members of the Society who have a special knowledge of the special subject, and we have always endeavoured to give judicious criticism rather than indiscriminate laudation. A writer in the *Medical Record* (Oct. 4th, 1902, p. 539) remarks that "an independent periodical seeking only the good of its readers and endeavoring to minister to their real needs must exert its beneficial influence in discriminating the good from the bad and in rendering a candid criticism of the best fruits of an open market. . . It is never a question if the volume will sell, but if it will fulfil the higher mission of profit to the reader."

We commend these remarks to the writers and the readers of our book reviews, and we trust that the portion of each of our numbers allotted to reviews will continue to be of interest and to give valuable instruction to our readers.

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The resignation by **Mr. W. H. Harsant**, F.R.C.S., of the office of surgeon to the Bristol Royal Infirmary is the first of many changes in the medical and surgical staff of the Infirmary which must of necessity arise in the course of a few years.

Mr. Harsant was elected Assistant Surgeon in 1879, and continued in this office till 1885, when he was elected Surgeon; the institution owes him a great debt of gratitude for his twenty-three years of assiduous and painstaking work, and many generations of students are much indebted to him for the punctuality and attention which he has always given to his clinical duties. His friends will all wish him many years of

continued activity in the less exacting work of his private and consulting practice at home.

* * * * *

The Executive Committee of the Gloucester, Somerset and Wilts Branch of the National Association for the Prevention of Consumption has not been as successful as we could wish in obtaining funds for the proposed Sanatorium at Winsley. Meetings have been held in various places, and a subscription list will shortly be published. At the meeting held in Gloucester the following remarks were made by Dr. Lionel Weatherly, who said:—

"It was proposed that the accommodation should at first be sixty beds, but as the patients were only retained for about three months, they would probably be able to treat at least three times that number of patients. They started the idea of building this Sanatorium solely and wholly from the philanthropic public and the self-help from the working classes. Owing possibly to the death of the Queen and the memorials to her memory got up all over the country, and this year the Coronation of the King and the consequent expenses to the public connected therewith, a check had been placed upon this philanthropic purpose, and they were bound to do what other sanatoria had done in other counties—come and ask the Town Councils to give them some support. That help could be given in this way: the Town Council could vote a sum to build one, two, or more beds in the sanatorium, and promise a further sum to maintain them. They would have the sole right of the beds they maintained, and a voice in the management. They wanted to apportion fifteen beds to each county (Bristol being reckoned as a county), and of that fifteen ten, they hoped, would be supported by the town councils, the county councils, by bodies of working men, by factories, or employers. These beds would belong to the bodies who maintained them. The other five beds for each county would be free to nominate any case by the payment of a small fee, not exceeding 10s. per week. It might be said—Would it not be better to let each county or district have its own sanatorium? His answer was that the experience in Germany, where they had spent hundreds of thousands of pounds in connection with this matter, was that it was absolutely essential that not only should the patients have fresh air and food, but they also needed hourly skilled medical supervision, and it was only under such skilled medical supervision that they could hope to arrest the disease in its early stages in the space of three or four months. Therefore, on the score of economy, it was not practicable to have an institution

with less than sixty beds. Bath had unanimously voted them £500 to build and maintain two beds, and Bristol City Council had unanimously passed a resolution to build and maintain four beds."

One of the most recent researches has been carried out by the Medico-Psychological Association of Great Britain and Ireland, which has done good work in appointing a Tuberculosis Committee for the investigation and collection of evidence and for practical suggestions as to the isolation of phthisical patients in Asylums. The report of the Committee has recently been issued, and their two years of work, under the chairmanship of Dr. Lionel A. Weatherly, has been summarised in the conclusions on page 383.

Notes on New Drugs and Preparations for the Sick.

We have received the following preparations from JAMES WOOLLEY, SONS & Co. Ltd., Manchester:

Akolethe; Sol. Sodæ Phenatis; Decalcified Bone; Elixir Terpini Co.; Elixir Triferrin; Sanitary Rose Powder; Phenate of Soda Tooth-paste.

The **Akolethe** is a solution of the sedative principles of opium of definite composition and uniform strength, equal to that of the Tinct. Opii. P.B. It is free from nauseous taste, and rarely produces any unpleasant after-effects. It has given excellent results, and is its own commendation—needing no other.

The **Solutio Sodæ Phenatis** is a strong antiseptic, resembling carbolic acid, but less caustic. When diluted in various degrees, it forms a useful application for all kinds of injuries to the skin and mucous membranes.

The **Phenate of Soda Tooth-paste** is a fragrant antiseptic for cleansing and preserving the teeth and gums.

The **Sanitary Rose Powder** has long been in use as a high-class toilet powder, with no irritating or pernicious properties. It is free from starch, is quite soluble, and acts as a deodorising antiseptic.

Cancellous Tissue (Decalcified Bone).—This substance seems well prepared, and, in one case in which we tried it, caused no inflammatory disturbance. Materials used for filling cavities made in operating upon bone, etc., have not met with much success, but Cancellous Tissue would certainly seem worth a trial.

The **Elixir Terpini Co.** is a combination of two very useful drugs—terpin and heroin. Each fluid drachm contains one grain of terpin hydrate, and one forty-eighth of a grain of heroin hydrochloride. It is an elegant syrupy preparation, which should have a wide range of utility in bronchitic and other respiratory affections. The dose is given as one to three drachms, but as much as four drachms would contain only an ordinary dose of the heroin. These cough sedatives may of course be abused, but, on the other hand, they give a great degree of comfort such as quite justifies their frequent use.

The **Elixir Triferrin** is a palatable preparation of a paranucleinate of iron. The Triferrin contains 22 per cent. of iron in organic combination, with 2½ per cent. of phosphorus. For adults the dose is four drachms. We cannot well have too many preparations of the indispensable drug ferrum: when one kind disagrees, it is convenient to resort to another with a different name; and the organic combinations sometimes give success where the inorganic iron salts have failed.

Milk Chocolate.—CADBURY BROTHERS LIMITED, Bournville, Birmingham.—This Chocolate is a confection of exquisite flavour, and a nourishing food of considerable value. It is made from cocoa, sugar, and milk from the pastures of Worcestershire. Analysis shows that it contains 30 per cent. of fats, 52 per cent. of sugar, and about 10 per cent. of albuminoids, with a very small proportion of indigestible fibre. It is entirely free from colouring matters and preservatives. It possesses excellent keeping qualities, and undergoes no deterioration in any climate. It is one of the best varieties of chocolate we have met with, and is in itself a fairly perfect food, combining the three essentials—fats, sugars, and albuminoids in proportion, to supply materials for a great amount of muscular and other work. No cyclist should be without it.

Dolle's Aromatic Iron Milk. (Lac. Ferri Aromat. Dolle)—THE BRITISH IRON MILK SYNDICATE LIMITED, Savoy House, London, W.C.—This is an entirely new preparation of iron, which contains pyrophosphate of iron, suspended in water, with glycerine, spirit, and aromatics. It is a white fluid, resembling milk, but with little taste, except aromatics. It does not blacken the teeth; and is not likely to cause either dyspepsia or

constipation. The dose is a teaspoonful to a tablespoonful, three times a day, after food. It is especially recommended in chlorotic cases, in dysmenorrhœa, neurasthenia, and debility, but above all, for rickety and scrofulous children. It is a kind of preparation which is likely to be very useful, especially for those patients who say they cannot take iron preparations in the usual forms.

Palatinoids.—OPPENHEIMER, SON & Co., London.—Pepsin, Pancreatin, Calcii Lactophosph. aa gr. j. (gastrodynic). One to three of these palatinoids, taken after meals, should give relief in most cases of functional dyspepsia not dependent on organic defect. The drugs are of good quality, and may be relied upon to retain their activity, as they are well preserved in this palatinoid form.

Antiphlogistine.—THE DENVER CHEMICAL MANUFACTURING Co., New York; 18 Jeffreys Road, Clapham Road, London, S.W.—This paste is composed of glycerine, boric acid, salicylic acid, iron carbonate, peppermint, gaultheria, eucalyptus, and iodine, combined with the base, silicate of alumina and magnesia.

Thermofuge.—Messrs. PARKE DAVIS & Co., London.—Under this name, a preparation similar to the above has been introduced: it is a stiff paste, composed of aluminium silicate, glycerine, boric acid, menthol, thymol, oil of eucalyptus, and ammonium iodide—an antiseptic combination for external use.

These external applications are designed to take the place of poultices, and to be used whenever poultices have been employed in cases of pneumonic and other internal congestions. They are first warmed, then spread on the skin in a fairly thick layer, and covered with cloth. They are easily applied and as easily removed, and have antiseptic and soothing effects. They are said to have all the virtues of the poultice without its vices, and to be well worthy of trial. The poultice has had its day: the new preparation takes its place.

Petanelle.—PATÉ, BURKE & Co., 6 Wool Exchange, London, E.C.—Petanelle Wool; Petanelle Nap; Petanelle Pads. These substances appear to be inferior to most surgical dressings in their power of absorbing discharges. When placed on water they do not sink, as most absorbent materials do; and, applied to a wound, we found that a large quantity of the discharge escaped under the dressing, instead of being absorbed thereby. The dark brown colour of the material will probably also militate against their use for surgical dressings, though this is a minor point, compared with their lack of absorption. The Petanelle Nap is elastic, and would make a good padding for splints.

Phillips' Milk of Magnesia.—THE CHARLES H. PHILLIPS CHEMICAL Co., New York; 14 Henrietta Street, London, W.C. —This milky-looking fluid is designed for the treatment of oral acidity, which is well known to be one of the most potent factors in the production of caries, erosions, and sensitive dentine. It is odorless, practically tasteless, milk-like in appearance, and contains 24 grains of magnesium hydroxide ($M_gH_2O_2$) to the fluid ounce of distilled water. It is free from grit, homogeneous, and non-irritating; it will neutralise twice its volume of lemon juice, and it neutralises acid saliva so completely that the alkalinity is maintained for hours. It is advised that a teaspoonful be taken into the mouth two or three times daily, particularly just before retiring. It should be worked with tooth-brush, tongue, and lips into all the spaces about the teeth, which will then remain coated with an alkaline film, protecting them from the action of acids for several hours.

All-glass Aseptic Hypodermic Syringe.—BURROUGHS, WELLCOME & Co., London —DIRECTIONS: Draw into the syringe the required quantity of sterile water, remove the nozzle, drop in the "Tabloid" Hypodermic Product, *carefully* replace the nozzle, and assist solution by shaking.

The syringe should be sterilised before and after use. To prevent sticking, each part should be thoroughly dried before it is replaced.

Owing to the precision with which the various parts fit, no lubricant is necessary. For the same reason, the vacuum within the cylinder should not be tested by placing the finger over the nozzle and drawing back the piston. The recoil will fracture the knob.

The barrel, piston, and nozzle consist entirely of glass, the solid piston **B** gliding evenly within the barrel **A**. The nozzle **C** fits into the barrel **A** by means of a perfect plug joint, and takes a needle **D** of the usual pattern. The principle of this syringe is that of what is called by engineers "the plunger," instead of the ordinary piston, and it works exceedingly well. It is always ready for action, and cannot get out of order. It is quite a pleasure to have one of these all-glass syringes at our disposal. They are made in two sizes, for 15 and 20 minims respectively.

We have also recently seen a much larger syringe, with an all-glass plunger, for the injection of antitoxin.

Vin Uranè Pesqui. Fassett & Johnson, 31 & 32 Snow Hill, London.—This uranated wine is prepared by Mr. Pesqui, of

Bordeaux, and is considered to be of much value in the treatment of diabetes. It is prepared by the addition of azotate of uranium, bromide of lithium, pepsine, quinine, and other drugs to an old Bordeaux wine (Medoc). It has a distinctly medicinal flavour, but is not unpleasant, and when diluted is an excellent thirst quencher. It is said that about ten bottles are usually necessary before the treatment can be considered complete, and that ten thousand deaths occur annually from diabetes in France, whereas they could have been prevented by means of the Vin Urané Pesqui! We can scarcely accept this statement as established fact.

The Library of the Bristol Medico-Chirurgical Society.

The following donations have been received since the publication of the List in September:

November 30th, 1902.

The Boston Medical Library (1) ... ... 82 volumes.
A. L. Flemming (2) ... ... 29 „
L. M. Griffiths (3) ... ... 10 „
The Medical Library, McGill University (4) ... 1 volume.
The Medico-Psychological Association of Great Britain and Ireland (5) ... ... 1 „
Dr. B. M. H. Rogers (6) ... ... 2 volumes.
The Editor of the "Virginia Medical Semi-Monthly" (7) ... ... 1 volume.

An unframed portrait has been presented by the Family of the late Dr. Neale, and unbound periodicals have been received from the Boston Medical Library, Mr. L. M. Griffiths, and Dr. B. M. H. Rogers.

FORTY-SIXTH LIST OF BOOKS.

The titles of books mentioned in previous lists are not repeated.

The figures in brackets refer to the figures after the names of the donors, and show by whom the volumes were presented. The books to which no such figures are attached have either been bought from the Library Fund or received through the *Journal*.

Allchin, W. H. [Ed.] *A Manual of Medicine*... ... ... Vol. IV. 1902
Beasley, H.... ... *The Pocket Formulary* ... ... (2) 5th Ed. 1851

Berry, R. J. A. ... *Regional Anatomy.* 3 vols. ... ... New [2nd] Ed. 1902
Björkstén, J. I. ... *Vaccinationens Historia i Finland* 1902
Bland-Sutton, J.... *See* **Sutton.**
Blumfeld, J. ... *Anæsthetics* 1902
Carless and W. Rose, A. *A Manual of Surgery* ... ... 5th Ed. 1902
Carpenter, W. B. *Human Physiology* ... ... (2) 3rd Ed. 1846
Carr, T. P. Pick, A. H. G. Doran and A. Duncan, J. W. *The Practitioner's Guide* 1902
Catalogue of the Specimens illustrating Surgical Pathology in the Museum of University College, London, Parts i., ii. ...(6) 1881–87
Charcot, [J. M.] ... *Clinique des Maladies du Système nerveux.* Tome ii. (3) 1893
Churchill, F. ... *Diseases of Women* ... ... (2) 3rd Ed. 1850
,, ... *Midwifery* ... ... (2) 2nd Ed. 1850
Cole, J. J. ... ... *Military Surgery* ... ... (2) 1852
Coles, A. C.... ... *The Blood*... ... ... 2nd Ed. 1902
Corfield, W. H. ... *Typhoid Fever* 1902
Doran and A. Duncan, J. W. Carr, T. P. Pick, A. H. G. *The Practitioner's Guide* 1902
Druitt, R. ... ... *The Surgeon's Vade-Mecum* (2) 2nd Ed., 1841, (2) 6th Ed. 1854
Duncan, J. W. Carr, T. P. Pick, A. H. G. Doran and A. *The Practitioner's Guide* 1902
Ede, R. B. ... ... *Practical Facts in Chemistry* ... ... (3) 1837
Ekgren, E. ... ... *Taschenbuch der Massage* ... . 1903 [*sic*]
Encyclopædia Medica. (Ed. by C. Watson). Vol. XI. 1902
Eyre, J. W. H. ... *The Elements of Bacteriological Technique* 1902
Fuller, H. W. ... *On Rheumatism, Rheumatic Gout, and Sciatica* ... (2) 1852
Gould and J. C. Warren, A. P. [**Eds.**] *The International Text-Book of Surgery.* Vol. II. 1900
Grant, H. H. ... *A Text-Book of Surgical Principles and Surgical Diseases of the Face, Mouth, and Jaws* 1902
Guibert, P. ... ... *The Charitable Physitian, with the Charitable Apothecary* (Tr. by J. W.)... ... ... (3) 1639
Haig, A. ... ... *Diet and Food* ... ... 4th Ed. 1902
Hamer, W. H. ... *Manual of Hygiene* 1902
Heath, [C.] .. ... *Practical Anatomy* (Ed. by J. E. Lane) ... 9th Ed. 1902
Hemmeter, J. C.... *Diseases of the Intestines*... ... ... 2 vols. 1901–02
Holmes, Life and Letters of. By J. T. Morse, Jr. 2 vols. 1896
Hutchinson, J. ... *An Atlas of Illustrations of Clinical Medicine, Surgery, and Pathology* 1902
Kayser, R. ... . *Kehlkopf-, Nasen- und Ohrenkrankheiten.* 2nd Ed. 1903 [*sic*]
Kenwood, L. Parkes and H. *Hygiene and Public Health.* ... ... 2nd Ed. 1902
Kirkby, W.... ... *The Evolution of Artificial Mineral Waters* 1902
Knuthsen, L. F. B. *Obstinate Hiccough* 1902
Latham, P. M. ... *Diseases of the Heart.* 2 vols. ... ... (3) 1846
Laurence, J. L. ... *Surgical Cancer* ... ... (2) 1855
Leech, D. J.... ... *Nitrites and Allied Compounds.* (Ed. by R. B. Wild) 1902
Lewers, A. H. N. *Cancer of the Uterus* 1902
Mattison, J. B. ... *The Mattison Method in Morphinism* 1902

Meade, [W.] ... *Manual for Students* ... ... (2) 2nd Ed. 1846
Moor, C. G.... ... *Suggested Standards of Purity for Foods and Drugs* ... 1902
Morse, J. T. (Jr.) *Life and Letters of Oliver Wendell Holmes.* 2 vols. ... 1896
Moynihan, A. W. M. Robson and B. G. A. *Diseases of the Pancreas* ... 1902
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Year-Book of Scientific and Learned Societies		1902

We think that our readers will be glad to have the following particulars on "The Growth of the Library since 1891."

In the *Journal* for December, 1891, there appeared a full account of the beginning of our Library, and its outcome from the success of the *Journal* was clearly traced. When the Library was opened on January 5th, 1891, in a room on the premises of the Literary and Philosophic Club, at 28 Berkeley Square, several volumes and many current periodicals were available for consultation by members. The growth of the Library can be most easily seen by a tabular record compiled from the Annual Reports of the Honorary Librarian, which have been read at the meetings of the Society held at the beginning of October.

Year.	Books.	Current Periodicals.	Duplicate volumes given to other Libraries or sold.
1891 ...	1,879 ..	79 ...	—
1892 ...	2,564 ...	79 ...	—
1893 ...	3,295 ...	108 ...	—
1894 ...	3,776 ...	108 ...	1
1895 ...	4,530 ...	127 ...	11
1896 ...	5,173 ...	158 ...	31
1897 ...	5,883 ...	172 ...	162
1898 ...	7,180 ...	170 ...	63
1899 ...	8,177 ...	188 ...	91
1900 ...	8,741 ...	189 ...	57
1901 ...	9,371 ...	189 ...	125
1902 ...	9,898 ...	189 ...	68

On the 16th of November, 1892, the New Medical School Buildings were opened, and a committee of an equal number of representatives of the Faculty of Medicine of University College and of the Society drew up a scheme for uniting the libraries of the two institutions, for although the staff of the School had not considered that its business was to provide books either for its teachers or its students, it must in fairness be stated that they were not at that time wholly without literature, for two volumes were discovered which there is every reason to believe were the property of the School.

On the 1st of July, 1893, the Society's books were moved to the Medical School into an apartment magnificent in its proportions and decorations, but strangely inadequate for a Library, although it had been specially designed for the purpose. The walls on three sides of the room were occupied for about three-quarters of their height by windows, which, although very beautiful in themselves, considerably lessened the wall space available for bookshelves, and it was soon necessary to erect shelves against the greater part of these windows.

When the junction of the two libraries was effected a clerk was put in charge of the books, giving to their care all his time which was not engaged with School work. It was shortly afterwards found that additional help was required, and an assistant clerk was appointed. In 1894, largely through the influence of Greig Smith, nearly all the

books belonging to the Royal Infirmary and the General Hospital were placed in the Library, which received a further increase by the transfer from the Museum and Library of the books which had originally belonged to the Medical Library situated in Orchard Street in the first half of the nineteenth century.

Owing to this fortunate combination, our members have access to 21,624 volumes and 227 current periodicals. These come from the following sources:—

	Books.	Current Periodicals.
Bristol Medico-Chirurgical Society ...	9,898 ...	189
Faculty of Medicine, University College	7,829 ...	38
Bristol Royal Infirmary	2,622 ...	—
Bristol General Hospital	1,275 ...	—
	21,624 ..	227

Those who wish to learn, or to remind themselves of, the facts concerning the development of the Library should refer not only to our number for December, 1891, but also to that for December, 1898, in which much is told concerning its advantages.

The cataloguing is done under the card-system, having one alphabetical list of authors, subjects, and titles, with plentiful cross-references.

The label which is attached to the insides of the covers of the books to denote ownership is utterly unworthy of our excellent Library, and steps ought to be immediately taken to procure two dignified book-plates, one for each main section of the Library.

In the matter of artificial illumination, the Library is sadly behind the times; and it would be nothing less than a scandal if it is true that the installation of the electric light was frustrated only by the jealousy of one of the other departments of the School. The College authorities have done much for the Library, and they doubtless would have done more if it had not been for the crippled state of their finances.

MEETINGS OF SOCIETIES.

Bristol Medico-Chirurgical Society.

Annual Meeting, October 8th, 1902.

After a vote of thanks to the retiring President (Dr. Barclay J. Baron) had been unanimously passed, Mr. G. Munro Smith took the chair and gave an introductory address (see p. 289), for which a cordial vote of thanks was afterwards given him.

The Honorary Secretary (Mr. J. Paul Bush, C.M.G.) read his Annual Report. The balance in hand was £80 2s. 6d., as compared with £63 7s. 9d. at the end of the previous session. He had to record that the Society had lost three of its members through death; viz., Dr. E. Long Fox, one of the founders of

the Society, Dr. Bonville Fox, and Mr. R. H. Chilton. Mr. C. K. Rudge had succeeded Mr. L. M. Griffiths as Librarian. The report was adopted, and thanks given to the Secretary for his services.

The EDITORIAL SECRETARY read his Report, which was adopted.

The Honorary Librarian of the Medical Library (Mr. C. K. RUDGE) gave his Annual Report, and stated that the Society's Library contained 9,898 volumes, including 899 duplicates; 595 volumes had been added to this Library in the course of the year, and 189 periodicals were regularly received. The Bristol Medical Library, of which the former was a part, contained 21,624 volumes, and received 227 periodicals.

The following officers were chosen for the ensuing year: President-elect, Mr. Paul Bush, C.M.G.; Members of Committee, Dr. J. Michell Clarke, Mr. J. Dacre, Dr. B. M. H. Rogers, Mr. J. Taylor, Dr. H. Waldo, and Dr. P. Watson Williams; and members of the Library Committee, Mr. C. K. Rudge, Mr. G. Munro Smith, and Mr. J. Taylor.

November 12th, 1902.

Mr. G. MUNRO SMITH, President, in the Chair.

Mr. A. W. PRICHARD showed a **"tumour of the omentum," which he had removed by operation** the preceding day from a female patient. The tumour had been noticed by the patient for two years, and for three weeks had caused a great deal of pain. More than once the patient had lost a good deal of blood from the uterus, and before the operation it had been thought that the tumour was probably a uterine fibroid. The tumour presented as a large mass in the right iliac region; it was well defined, somewhat movable, and peculiarly resonant all over. The hand could be placed between it and the symphysis pubis. Vaginal examination showed the uterus to be situated very high up, and the cervix patulous and directed backwards. Movements given to the tumour were not apparently communicated to the cervix. The tumour had been easily brought outside the abdomen through a free median incision. The intestines were widely adherent to it. It had been removed together with the adherent intestine. The divided ends of the intestine had been united end to end with the aid of O'Hara's forceps. The latter instrument had much facilitated the suturing of the intestine, of which about 49 inches had been removed. The patient up to the present was progressing well.

Dr. A. OGILVY showed a patient with **congenital subluxation of both crystalline lenses.** He remarked that the affection was supposed to be met with about once in each five thousand cases

of eye disease. The patient, a schoolgirl, had been brought to the Eye Dispensary by her mistress, because she could not see well except from the front form in the school. Such displaced lenses were always found to the side of, or to the side of and above, the normal position, never below. In some the lens slipped forward into the anterior chamber, and then there was a risk of glaucoma supervening. Needling the lens was not a satisfactory procedure, as the lens moved about before the needle. It had been suggested to fix the lens with one needle and break it up with another; but the results seemed hardly to warrant interference. The patient had myopia when she looked through the lens, hypermetropia when she looked through the apophyc part. Examined by oblique illumination, the lens looked greyish. It was proposed to leave the case alone.—Mr. CYRIL WALKER thought these cases were actually rarer than statistics appeared to show, because patients with the affection were likely to wander from one institution to another. He mentioned an example of this. With regard to treatment, it should be borne in mind that the lenses were always somewhat opalescent, as seen when the pupil was widely dilated. In one case, in which the lens was widely dislocated, and in which the patient saw by the side of the lens, he had been able to estimate and correct the errors of refraction, but even then sight remained so imperfect that it was obvious that removal of the lens would be of no advantage.—Dr. PROWSE mentioned a case he had seen many years ago in which the lens was dislocated about half-way across the pupil.

Dr. W. H. C. NEWNHAM showed **a specimen of Tumour of the Uterus removed by Intra-peritoneal Hysterectomy.** The specimen presented some peculiarities. The patient was a married woman of thirty years of age, who had had no children. She had been sent to him complaining of an abdominal tumour and profuse uterine hemorrhage. The hemorrhage had been so profuse for eighteen months that the patient was quite blanched. A large tumour, moving with the uterus, was found on examination. The uterus, with the tumour, which was a large fibroid, was removed by retro-peritoneal hysterectomy. For a minute during the operation, when the uterus was cut into, and the tumour bulged out, looking as it did like placental tissue, he had feared that he had incised a pregnant uterus. The patient was now well.—Mr. W. ROGER WILLIAMS remarked that the number of deaths from hemorrhage in cases of uterine fibroids was difficult to decide. It was difficult to collect half a dozen cases. When such tumours had projected into the uterine cavity and broken down, they had been sometimes mistaken for malignant tumours. On the other hand, some such tumours had been reported upon as being innocent, by committees of learned societies, from microscopical examination, and yet recurrence had subsequently shown that the tumours were malignant. Probably the tumour in the present instance had

its origin in the fundus of the uterus, where the two lateral halves of the organ became fixed during development.—Mr. PAUL BUSH asked if the tumour had caused any pressure symptoms, and alluded to a case in which he had to remove such a tumour for intestinal obstruction, due to the pressure it produced. From the symptoms, malignant stricture of the intestine had been surmised.—Dr. NEWNHAM replied that no pressure symptoms had arisen. The tumour had not presented through the cervix.

Mr. J. TAYLOR read a paper on the "**Clinical Use of High-Frequency Currents**," and showed the apparatus used. The speaker first defined what was meant by the term "high-frequency currents," and demonstrated the different parts of the apparatus used for their production, and the methods of applying the current to obtain therapeutical effects. Cases of phthisis and diabetes had been reported as cured by this agency. The speaker then described some of his own clinical results. He had tried it in three cases of malignant disease. In an epithelioma of the ear and in an epithelioma of the groin, secondary to epithelioma of the vulva, the result had been *nil*. In a case of sarcoma of the orbit, the effects had been encouraging. Pain had been alleviated, the growth had become smaller, the power of hearing, previously lost, had been regained, and there had been a slight return of visual power. One patch of lupus in the forearm, which had recurred after treatment by caustics, was cured. A case of paralysis agitans derived benefit. In a case of labyrinthine deafness with tinnitus, the latter symptom had been relieved, but not the deafness. The patient herself was pleased with the result, and came back from time to time to have the treatment re-applied. A man of 80 years of age, with osteo-arthritis, and so much stiffness of the shoulder-joints that he could not remove his hat, but without grating in the joints, had been much improved, and he could now dress himself. A man of 50, with obstinate and severe sciatica of three months' duration, had been treated with brilliant success. At first he had to be carried to the room in which the treatment was given. After a few applications he could walk, and after a month could run, and the wasting of muscles previously noted had disappeared. In some simple ulcers the treatment had been successful. In one case, associated with necrosis of bone, the treatment had appeared to the speaker to hasten the separation of a sequestrum and healing of the wound. It had been effectual for a tubercular ulcer in an abdominal scar, the result of a laparotomy for tubercular peritonitis, but on the other hand, on a tubercular sore in an amputation stump, and in a case of tubercular tenosynovitis of the ankle region, the effects had been *nil*. In two cases of fissure of the anus, one associated with hemorrhoids, the fissures had been healed by the treatment, and the hemorrhoids had been benefited. A case of pruritus ani of twenty years

standing was apparently cured.—Dr. WALTER SWAYNE stated that from personal experience he could say that the pain of a stiff neck could be relieved for four or five hours by this treatment, but he could not say that the duration of the trouble had been lessened.—Dr. KENNETH WILLS said that all branches of the profession should unite together to settle the question as to the utility of the various forms of electrical treatment now being tested. He was himself convinced that good was being done in various directions, and that the electrical methods of treatment were not destined to fizzle out.—Dr. GEORGE PARKER agreed with the last speaker. So much quackery had been associated with electrical treatment in the past, that a thorough testing of its value was necessary. It was clear that the improvement in many of Mr. Taylor's cases could not be put down to "suggestion."—Dr. ODERY SYMES alluded to the alleged inhibitory effect of the currents on the bacillus pyocyaneus. If such effects were produced, then the effect of these currents was quite different to that of X-rays, for the latter had been shown to have no effect whatever on micro-organisms.—Mr. W. ROGER WILLIAMS asked if Mr. Taylor knew of any case of malignant disease which had been caused by the treatment. Cases had been reported in which X-rays had been supposed to cause the growth of tumours.

Dr. P. WATSON WILLIAMS described a **Case of Aneurism of the Aorta simulating Mediastinal New Growth**, and showed the specimen which had been obtained from the case. During life he had regarded the case as one rather of mediastinal tumour than of aneurism. The superior vena cava was almost obliterated, being flattened between the aneurismal sac and the chest wall.—Dr. E. MARKHAM SKERRITT said that he had not seen the patient. He thought the position of the growth rather pointed to its aneurismal nature. The absence of pulsation in such cases was accidental, and depended upon the size of the mouth of the aneurism. Absence of hypertrophy of the heart was not against aneurism. An aneurism did not give increased work to the heart, and hypertrophy would only be likely to occur if there was coincident valvular disease.—Mr. ROGER WILLIAMS asked if the pulse had been dicrotic, and if a sphygmographic tracing had been taken.—Dr. CAVE alluded to statistics which had been collected, showing that cardiac hypertrophy was not common in aneurism.—Dr. THEODORE FISHER described the way mediastinal tumours tended to block veins but not arteries.—Dr. MICHELL CLARKE said that in his experience extreme distension of superficial veins had been present more often in aneurism than in growth. He had only once met with tracheal tugging without an aneurism. He attached great importance to an alteration in the basic heart sounds in the diagnosis of aneurism, and asked if they had been altered in the present case. He had found the greatest difficulty in diagnosing aneurisms affecting the descending aorta, and he mentioned cases in which

patients had not had spinal tenderness nor fixation, though vertebræ had been extensively eroded. In one such case death resulted from dysphagia.—Dr. WATSON WILLIAMS replied that in his case there had been no peculiarity in the pulse, no bruit, and no accentuation of the second cardiac sound.

Dr. J. MICHELL CLARKE read a paper on a **Case of Banti's Disease** (to be published in our next number), which was discussed by Drs. SYMES, FISHER, and PARKER.—Dr. SYMES mentioned a case of Banti's Disease which had ended fatally in the Bristol General Hospital in 1901. The blood count was as follows: red cells, 2,800,000; white cells, 6,000 per c.mm. The differential count of the latter showed: finely granular oxyphil leucocytes, 56 per cent.; coarsely granular ditto, 25 per cent.; large lymphocytes, 12 per cent; small lymphocytes, 28 per cent.; and a few granular basophils. The enlarged spleen and liver showed fibrosis only. There was a scar of an old infarct in the lung.

J. LACY FIRTH.
J. PAUL BUSH.

Local Medical Notes.

University College, Bristol.—Mr. O. S. Bodman, M.B., B.S., M.R.C.S., L.R.C.P., has obtained the degree of M.D. of the Durham University; Messrs. H. Devine and W. N. Blatchford have obtained the M.R.C.S. and L.R.C.P. diplomas, and Mr. A. R. Mc Ennery the L.S.A. diploma. Messrs. A. N. Thomas and H. O. Gough were successful in the Intermediate M.B. Examination of the London University.

The Bristol Royal Infirmary.—The following appointments have recently been made: W. H. Harsant, F.R.C.S., Consulting Surgeon; James Swain, M.S., M.D. Lond., F.R.C.S., Honorary Surgeon; Harold F. Mole, F.R.C.S., Assistant Surgeon; C. A. Hayman, M.D. St. Andrews, F.R.C.S.I., L.D.S., Honorary Dental Assistant; John A. Nixon, B.A., M.B., B.C. Cantab., Senior Resident Officer and House Physician; E. H. Edwards Stack, M.B., B.C. Cantab., F.R.C.S., House Surgeon; H. E. Stanger-Leathes, M.R.C.S., L.R.C.P., Casualty Officer; and A. W. Conolly, M.R.C.S., L.R.C.P., Junior House Surgeon.

The Bristol General Hospital.—Mr. Charles Corfield has been appointed Casualty Assistant House Surgeon; Mr. C. C. C. Shaw, M.B. Lond., M.R.C.S., L.R.C.P., Assistant House Physician; Mr. J. W. Llewellyn, M.R.C.S., L.R.C.P., Assistant House Surgeon.

The Royal Victoria Homes, Brentry.—This useful institution forms the inebriate reformatories for various counties and boroughs, and is doing good work in our midst.

It was commenced in the year 1887, when the Rev. H. N. Burden, the present Warden of the Royal Victoria Homes, originated a scheme for the establishment of a home for the reception of criminal habitual drunkards, and a few years afterwards an institution of this sort was opened at Horfield, and in March, 1898, was licensed under the Inebriates' Act (1898) for the reception of 20 women.

In consequence of support by various county councils and municipal authorities, twenty-four of which are now subscribers, Brentry House was secured in addition, and in January, 1899, licensed for 50 female cases. The Home has rapidly increased, and is now licensed for 25 women at Horfield, which is used as the female "receiving house"; Brentry House is licensed for 200 women and 111 men; Ashford for 75 females (Roman Catholics); and in order that a better classification can be carried out, homes also in connection with Brentry have within the last few weeks been opened at Lewes and Chesterfield to receive 120 and 57 women respectively.

A few unmanageable cases can be sent by the Secretary of States' order to the State Reformatories, which have been opened at the prisons at Warwick (for men) and Aylesbury (for women).

From the Warden's Report (1901) we learn that the admissions during the year number in all 171 persons, 166 of whom were convicted under the Inebriates' Act of 1898, the remaining five persons, being two men and three women, were received under the Act of 1879. Of the persons convicted under the Act of 1898, 133 were women and 33 men. In age they range from 18 up to 70; twenty-eight of the women were under 30 years of age, forty-nine were between that age and 40, forty-one between 40 and 50, fourteen between 50 and 60, and one over 60 years of age. Three of the men were under 30, eleven between 30 and 40, ten between 40 and 50, five between 50 and 60, and four over 60 years of age.

From the report of the medical officer, Dr. H. L. Ormerod, we find that all medicines have been administered in a solid form, as by this means the tendency to frequent "sipping" is avoided, and also the desire to be on the "sick list" is diminished.

The Institution appears to be doing good work, and is under excellent management.

Tuberculosis in Asylums[1] (*vide* p. 368).—Phthisis is prevalent in our public asylums to an extent which calls for urgent measures.

[1] Extract from Report of the Tuberculosis Committee of the Medico-Psychological Association of Great Britain and Ireland, 1902.

A very large number of cases of phthisis have acquired that disease after admission to the asylum.

The special causes for this increased prevalence of phthisis in our asylums are in our opinion:—

Overcrowding, with consequent insufficient day, and especially night, cubic space per patient;

Insufficiency of hours in the open air;

Defects in ventilation and heating;

Uncleanly habits; and

Faults in dietary.

[On the other hand, it is a commonly recognised fact that in some asylums tuberculosis is so rare as to be practically unknown; and it would appear as if admission to these asylums would be one of the best modes of treatment. It has frequently been noted how much the duration of life in the paretic patient is prolonged by the hygienic surroundings and ample feeding of a model asylum: in fact, by the best treatment of tuberculosis. —Ed.]

The means of prevention should be:—

Early diagnosis of phthisis;

Isolation of all phthisical cases;

Limiting the size of future asylums;

Checking overcrowding;

Increasing day and night cubic space;

Restricting number of beds in dormitories;

Increased and more thorough natural ventilation per patient;

The greatest care to prevent the spread of the disease by promiscuous spitting;

A careful supervision of dietary;

Properly constructed and situated hospitals and sanatoria, with adequate and suitable surroundings for the isolation of these cases, and their treatment on the most modern lines; and

Failing such special hospitals or sanatoria, then either temporary isolation hospitals or special wards and airing courts set apart for this purpose.

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